coOportunity HEALTH®

2015 PPO Plans

CoOportunity **Premier** Outline of Coverage

Plan Options: Catastrophic, Bronze, Silver, Gold

Including Cost Sharing Reduction Plans

Qualified Health Plans for Individuals and Families in Nebraska

For coverage beginning January 1, 2015

Plans offered on the Nebraska Health Insurance Marketplace and Off Exchange

IN NEBRASKA

M-00011 (11/14)

CoOportunity Premier

CoOportunity Premier is a PPO plan design that offers broad provider choice with cost savings for accessing care through in-network providers. CoOportunity Premier features the Midlands Choice Premier provider network which includes 100% of hospitals and 97% of practitioners in Nebraska. All plan design levels feature no or low copays for primary care office visits — emphasizing the importance of establishing ongoing care with a trusted medical home or practitioner.

The CoOportunity Premier plans outlined here and detailed in the Individual Policy and Benefits Chart are designed to provide benefits for covered medical expenses incurred as a result of a covered illness or injury. Covered services are subject to deductible, coinsurance and copayment provisions, or other limitations set forth in your Policy.

Unless otherwise indicated, CoOportunity Premier plans meet the requirements of the Patient Protection and Affordable Care Act for coverage and out-of-pocket costs. This includes coverage for essential health benefits such as hospitalization, outpatient services, emergency services, maternity and newborn care, mental health services, and prescription drugs. In addition, there are no out-of-pocket costs for preventive services received from in-network providers. Pediatric dental services are not included; this coverage is available as stand-alone plans in the Nebraska Health Insurance Marketplace.

Types of Enrollment

Single Coverage: Provides coverage to the policyholder only.

Family Coverage: Provides coverage to the policyholder and eligible family members.

Enrollment Periods

Open Enrollment Period. Open enrollment begins on November 15, 2014 and extends through February 15, 2015. The annual open enrollment period and the date you have to enroll yourself and any eligible dependents are defined under federal law and may vary.

Special Enrollment Period. You are eligible to enroll outside of the open enrollment period if you qualify for a special enrollment period. The following are some examples of events that qualify for a special enrollment period:

You must enroll yourself and any eligible dependents within 30 days if any of these events occur:

- If you or your dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours.
- If you or your dependent lose group coverage because of the death of the enrollee.
- If you or your dependents lose group coverage because of a divorce, legal separation, or termination of domestic partnership.
- If your dependent loses group coverage because of loss of eligibility as a dependent child.
- If you or your dependents lose group coverage because the group enrollee's initial enrollment for Medicare.
- For a retired enrollee, spouse and other dependents, if you lose group coverage because of bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

You must enroll yourself and any eligible dependents within 60 days if any of these events occur:

- If you or any of your eligible dependents lose minimum essential coverage.
- Newly acquired dependents through marriage, domestic partnership, birth, adoption, or placement for adoption.
- If you become a citizen, national or lawfully present individual in the U.S.
- If you are qualified, but experience an error in enrollment.
- If you are enrolled in another Qualified Health Plan and you successfully demonstrate to the Exchange that your Qualified Health Plan has substantially violated a material provision of its contract.
- If you are newly eligible or lose eligibility for advance payment of the premium tax credit, or you experience a change in eligibility for cost sharing reductions.

- If you become eligible for new Qualified Health Plans offered through the Exchange because of a permanent move.

Late Enrollment. If you do not enroll yourself or any eligible dependents during the annual open enrollment or within 60 days of a special enrollment period, you must wait until the next annual open enrollment period to enroll yourself and any eligible dependents.

Note: The following events are not considered loss of coverage and do not qualify for a special enrollment period:

- Voluntarily canceling other health insurance coverage
- Losing coverage that doesn't qualify as minimum essential coverage
- Being terminated for not paying premiums

Enrollment of Newborn or Newly Adopted Children. CoOportunity Health will provide benefits for newborn infants (including an enrollee's newborn grandchild who is financially dependent on the covered grandparent) from the moment of birth, and for newly adopted children, from the date of placement, for the first 31 days without any additional premium. Newborn children and newly adopted children **are subject to a separate deductible**.

The member must notify CoOportunity Health of the birth or adoption and **pay any required premium** within 60 days of the child's birth or placement for adoption, in order to enroll the child and continue coverage beyond the first 31 days.

The member may enroll the child in a separate single plan, add the child to the member's existing individual plan, converting the plan to a family plan, or add the child to an existing family plan.

If the member wishes to enroll newborn children or newly adopted children after the 60-day special enrollment period, the child will not be eligible to enroll until the next open enrollment period or other qualifying life event occurs.

Nebraska Provider Network

CoOportunity Premier uses the Midlands Choice Premier network, a PPO network with more than 33,500 physicians and other health care professionals, 339 hospitals, and more than 1,700 other health care facilities in Nebraska, Iowa and bordering states.

In Nebraska, 100 percent of the hospitals and 97 percent of the clinicians contract with Midlands Choice. You save money when you use in-network providers. In most cases, your out-of-pocket costs such as coinsurance are less when you receive care from in-network providers. In addition, in-network providers accept our negotiated/contracted payment for covered services as payment in full and cannot balance bill you for any unpaid balance remaining for those covered services. Please note that you are still responsible for paying network providers for your out-of-pocket costs such as deductibles, copayments, coinsurance and charges for services not covered.

You'll have higher out-of-pocket costs with out-of-network providers. In addition, out-of-network providers are not obligated to accept payment as payment in full and can balance bill you for the remaining difference.

To locate providers who contract with Midlands Choice and review their professional qualifications, visit **coOportunityhealth.com/ProviderSearch**.

National Provider Networks

When traveling for work or while on vacation, you can be confident you can receive care from an in-network provider through our seamless solution of national provider networks — the PHCS Network and the MultiPlan network.

The PHCS Network is the largest independent primary PPO network in the country with providers in all 50 states. The PHCS Network includes more than 4,200 hospitals, 68,000 ancillary care facilities and 590,000 health care professionals.

The MultiPlan network is a nationwide provider network that complements the PHCS Network by giving access to an additional choice of providers at discounted rates. More than 4,600 hospitals, 93,000 ancillary care facilities and 620,000 providers are included in the MultiPlan network.

To receive in-network benefits when traveling, simply use PHCS Network or MultiPlan network. The providers will file the claims for you and you'll enjoy in-network savings.

Visit **coOportunityhealth.com/ProviderSearch**.

See ***Terms to Know*** on page 7

CoOportunity Premier Plan Comparison Chart

Out-of-Pocket Costs for CoOportunity Premier Qualified Health Plans Available on the Nebraska Health Insurance Marketplace (Exchange) and Off-Exchange

Plan Benefits	Catastrophic*		Bronze*		Silver		Gold	
Deductible (Individual/Family)	$6,600/$13,200		$6,600/$13,200		$4,000/$8,000		$1,600/$3,200	
Coinsurance	0%		0%		30%		20%	
Out-of-Pocket Max (Individual/Family)	$6,600/$13,200		$6,600/$13,200		$6,600/$13,200		$3,200/$6,400	
Medical Benefits	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Preventive Care/Screenings/ Immunizations	$0		$0		$0		$0	
First Three Office Visits Free (Includes Primary Care, Specialists & Outpatient Behavioral Health)	No		No		Yes		Yes	
Primary Care Visits	$25 for first 3 visits; then deductible applies	✔	$25 for first 3 visits; then deductible applies	✔	$20		$20	
Specialist Visits	$0	✔	$0	✔	$40		$40	
Behavioral Health (Inpatient)	$0	✔	$0	✔	30%	✔	20%	✔
Behavioral Health (Outpatient)	$25 for first 3 visits; then deductible applies	✔	$25 for first 3 visits; then deductible applies	✔	$20		$20	
Habilitative & Rehabilitative Services (Physical Therapy, Occupational Therapy, Speech Therapy)	$0	✔	$0	✔	$20 (Primary Care) $40 (Specialist)		$20 (Primary Care) $40 (Specialist)	
Laboratory Services (Outpatient)	$0	✔	$0	✔	30%	✔	20%	✔
X-Ray/Diagnostic Imaging	$0	✔	$0	✔	30%	✔	20%	✔
High-Tech Imaging (MRI/CT/PET)	$0	✔	$0	✔	30%	✔	20%	✔
Emergency Room Services (Waived If Admitted)	$0	✔	$0	✔	$250 plus coinsurance	✔	$250 plus coinsurance	✔
Home Health Care	$0	✔	$0	✔	30%	✔	20%	✔
Inpatient Admission	$0	✔	$0	✔	30%	✔	20%	✔
Outpatient Services	$0	✔	$0	✔	30%	✔	20%	✔
Skilled Nursing Care	$0	✔	$0	✔	30%	✔	20%	✔
Hospice	$0	✔	$0	✔	30%	✔	20%	✔
Durable Medical Equipment	$0	✔	$0	✔	30%	✔	20%	✔
Temporomandibular Disorders (TMD) (Inpatient & Outpatient)	$2,500 Benefit Period Maximum	✔	$2,500 Benefit Period Maximum	✔	$2,500 Benefit Period Maximum	✔	$2,500 Benefit Period Maximum	✔
Prescription Drug Benefits	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Preferred Generic Drugs	$0	✔	$10		$10		$10	
Preferred Brand Drugs	$0	✔	$0	✔	$40		$40	
Non-Preferred Generic & Brand Drugs	$0	✔	$0	✔	$80		$80	
Specialty & High-Cost Drugs	$0	✔	$0	✔	30%		20%	
Routine Pediatric Vision Services	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Eye Exam	$0		$0		$0		$0	
Prescription Glasses & Frames (Limit One Pair Per Year)	$0	✔	$0	✔	30%	✔	20%	✔
Out-of-Network Benefits								
Deductible (Individual/Family)	$13,200/$26,400		$13,200/$26,400		$8,000/$16,000		$3,200/$6,400	
Coinsurance	0%		0%		50%		40%	
Out-of-Pocket Max (Individual/Family)	$13,200/$26,400		$13,200/$26,400		$16,000/$32,000		$6,400/$12,800	

CoOportunity Premier plans do not include pediatric dental services. This coverage is available on the Nebraska Health Insurance Marketplace and can be purchased as stand-alone coverage.

*For Catastrophic and Bronze plans, services are covered at 100% after you meet the $6,600 individual or $13,200 family deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be met through any combination of family members.

Deductibles, copays and coinsurance apply toward the out-of-pocket maximum.

CoOportunity Premier Plan Comparison Chart

Out-of-Pocket Costs for CoOportunity Premier Cost Sharing Reduction Qualified Health Plans Available ONLY Through the Nebraska Health Insurance Marketplace (Exchange)

CoOportunity Premier benefit designs displayed below are available for enrollment ONLY through the Nebraska Health Insurance Marketplace. You must meet income requirements in order to enroll in these plans.

	Available only on Nebraska Health Insurance Marketplace					
Plan Benefits	**Silver CSR94**		**Silver CSR87**		**Silver CSR73**	
Deductible (Individual/Family)	$275/$550		$750/$1,500		$2,500/$5,000	
Coinsurance	30%		30%		30%	
Out-of-Pocket Max (Individual/Family)	$550/$1,100		$1,500/$3,000		$5,000/$10,000	
Medical Benefits	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Preventive Care/Screenings/ Immunizations	$0		$0		$0	
First Three Office Visits Free (Includes Primary Care, Specialists & Outpatient Behavioral Health)	Yes		Yes		Yes	
Primary Care Visits	$20		$20		$20	
Specialist Visits	$40		$40		$40	
Behavioral Health (Inpatient)	30%	✔	30%	✔	30%	✔
Behavioral Health (Outpatient)	$20		$20		$20	
Habilitative & Rehabilitative Services (Physical Therapy, Occupational Therapy, Speech Therapy)	$20 (Primary Care) $40 (Specialist)		$20 (Primary Care) $40 (Specialist)		$20 (Primary Care) $40 (Specialist)	
Laboratory Services (Outpatient)	30%	✔	30%	✔	30%	✔
X-Ray/Diagnostic Imaging	30%	✔	30%	✔	30%	✔
High-Tech Imaging (MRI/CT/PET)	30%	✔	30%	✔	30%	✔
Emergency Room Services (Waived If Admitted)	$250 plus coinsurance	✔	$250 plus coinsurance	✔	$250 plus coinsurance	✔
Home Health Care	30%	✔	30%	✔	30%	✔
Inpatient Admission	30%	✔	30%	✔	30%	✔
Outpatient Services	30%	✔	30%	✔	30%	✔
Skilled Nursing Care	30%	✔	30%	✔	30%	✔
Hospice	30%	✔	30%	✔	30%	✔
Durable Medical Equipment	30%	✔	30%	✔	30%	✔
Temporomandibular Disorders (TMD) (Inpatient & Outpatient)	$2,500 Benefit Period Maximum	✔	$2,500 Benefit Period Maximum	✔	$2,500 Benefit Period Maximum	✔
Prescription Drug Benefits	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Preferred Generic Drugs	$10		$10		$10	
Preferred Brand Drugs	$40		$40		$40	
Non-Preferred Generic & Brand Drugs	$80		$80		$80	
Specialty & High-Cost Drugs	30%		30%		30%	
Routine Pediatric Vision Services	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Eye Exam	$0		$0		$0	
Prescription Glasses & Frames (Limit One Pair Per Year)	30%	✔	30%	✔	30%	✔
Out-of-Network Benefits						
Deductible (Individual/Family)	$550/$1,100		$1,500/$3,000		$5,000/$10,000	
Coinsurance	50%		50%		50%	
Out-of-Pocket Max (Individual/Family)	$1,100/$2,200		$3,000/$6,000		$10,000/$20,000	

The family deductible and out-of-pocket maximum can be met through any combination of family members.

Deductibles, copays and coinsurance apply toward the out-of-pocket maximum.

For individuals and families of American Indian or Alaska Native ethnicity

If you are a member of a federally recognized Indian tribe or Alaska Native tribal entity, you qualify to enroll in unique, low cost health insurance products that are only available to American Indians or Alaska Natives. CoOportunity Health offers these special plans on the Health Insurance Marketplace (Exchange). Please go to the Nebraska Health Insurance Marketplace at **healthcare.gov** to enroll.

Prescription Drug Coverage

CoOportunity Premier plans include benefits for prescription drugs and medications that are self-administered or administered in a physician's office. Certain off-label uses are covered as specified in the policy and benefits chart. In-network and non-network benefits apply to coverage for prescription drug categories such as:

- Outpatient drugs
- Contraceptive drugs
- Tobacco cessation products (must be prescribed by a licensed provider)
- Mail order drugs
- Specialty drugs that are self-administered
- Drugs for treatment of growth deficiency

Prescription Drug Benefit Design

Prescription drug benefits are based on the CoOportunity Health Drug List which is structured in four categories or "tiers." The cost share you pay for each 31-day retail supply of your covered prescription drug depends on the tier in which your medication is listed. To access the drug list, go to **coOportunityhealth.com/DrugList**. Cost shares apply toward the out-of-pocket maximum.

Silver and Gold Plans			
Formulary Generic Drugs	**Formulary Preferred Brand-Name Drugs**	**Non-Preferred Drugs**	**Specialty & High-Cost Drugs**
$10 copay	$40 copay	$80 copay	Coinsurance (varies by metal level)

Note: For Catastrophic and Bronze plans, prescription drug coverage is covered at 100% **after** you meet your $6,600 deductible and out-of-pocket maximum, except for generic drugs in the Bronze plan.

Retail Pharmacies

MedImpact is the pharmacy benefits manager (PBM) for CoOportunity Health. The MedImpact network includes more than 65,000 retail pharmacies across the U.S. Take your prescription to a participating MedImpact pharmacy and show the pharmacist your CoOportunity Health ID card. You pay the appropriate copay amount (see table) based on how the medication is classified. To find a network pharmacy, contact member services or go to **coOportunityhealth.com/Pharmacy**.

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

Mail Order Service

Outpatient long-term maintenance prescription drugs may be ordered through the CoOportunity Health mail order service. If you order a 93-day supply, or portion thereof, we cover 100% of the allowed amount, subject to your copayment of $20 for generic formulary drugs and $80 for preferred formulary brand name drugs. Non-preferred drugs are covered subject to a copayment of $240. Specialty drugs are not available through the mail order service. Enrollment information about this service can be found at **coOportunityhealth.com/Member/UsingBenefits**.

Specialty & Growth Deficiency Drugs

Specialty drugs are limited to drugs on the specialty drug list and growth deficiency drugs are limited to drugs on the growth deficiency drug list; all drugs in these categories must be obtained from CoOportunity's specialty drug vendor, CVS Caremark Specialty Pharmacy and are limited to a 31-day supply per fill. More information about ordering specialty drugs can be found at **coOportunityhealth.com/Member/UsingBenefits**.

Quantity Limits, Step Therapy & Prior Authorizations

Drugs covered under your benefits policy may be limited per month, benefit period, or lifetime by specific quantity limitations. These limitations are determined by CoOportunity Health based on medical necessity. In addition, certain drugs may require prior authorization or step therapy to verify that the drug is medically necessary and part of a specific treatment plan; your healthcare provider must call to obtain approval. For a list of drugs subject to quantity limits, or to determine whether a drug you are taking requires prior authorization, check with your pharmacist or provider, contact Member Services or go to **coOportunityhealth.com/DrugList**.

Terms to Know

Brand Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand drug has expired. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

Generic Drug: A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand drug. Generally, generic drugs cost less than brand drugs. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

Drug Formulary: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies covered by us as indicated in the Benefits Chart which are covered at the highest benefit level. Some drugs on the formulary may require authorization to be covered as formulary drugs. To review the drug formulary, go to **coOportunityhealth.com/DrugList**.

Network Provider: This is any one of the participating licensed physicians, dentists, mental and chemical health or other healthcare providers, facilities and pharmacies listed in the network directory, that has entered into an agreement with Midlands Choice to provide healthcare services to CoOportunity Health members. This plan is an open-access plan which means you can access any network provider without a referral from a primary care provider or the health plan.

Non-Preferred Drug: This is a medically necessary prescription drug which is not on the formulary and is not investigative or otherwise excluded under the Policy.

Primary Care Providers: These are providers in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Adolescent Medicine, Adult Medicine and Geriatrics. Members of this plan have access to these providers without a referral or authorization from the plan.

Specialty Care Providers: These providers practice in the specialty and subspecialty categories including, but are not limited to: Allergy/Immunology, Behavioral Medicine, Cardiology, Gastroenterology, Neurology, Oncology, Orthopedics, Pulmonology, Surgery. Members of this plan have access to these providers without a referral or authorization from the plan.

Specialty Drug List: This list includes specialty and high-cost drugs typically used for treating or managing complex or chronic illnesses. Administration of these drugs may include the following methods: injected, infused, inhaled, orally administered, or topically applied. These drugs often require special handling and administration and may have limited access or distribution through an approved pharmacy. Specialty and high-cost drugs are covered by us as indicated in the Prescription Drug Services section.

A current list of specialty and high-cost drugs is available by calling Member Services, or logging on to your account at **coOportunityhealth.com**. This list may be revised from time to time.

Covered Benefits

Unless otherwise indicated, CoOportunity Premier plans meet the requirements of the Patient Protection and Affordable Care Act for coverage and out-of-pocket costs. This includes coverage for essential health benefits such as hospitalization, outpatient services, emergency services, maternity and newborn care, mental health services, and prescription drugs. In addition, there are no out-of-pocket costs for preventive services.

Inpatient Hospital Services

Coverage is provided for medically necessary services and supplies related to the treatment of illness or injury in an inpatient facility. Benefits are available for, but not limited to, the following covered services:

- Anesthesia
- Intensive care facilities
- General nursing care
- Laboratory and diagnostic imaging services
- Newborn nursery facilities
- Other diagnostic or treatment-related hospital services
- Physician and other professional medical and surgical services provided while in the hospital
- Physical therapy
- Prescription drugs or other medications administered during treatment
- Radiation therapy
- Room and board
- Use of operating or maternity delivery rooms
- Rehabilitative and habilitative services

Outpatient, Ambulatory or Surgical Facility Services

Coverage includes the use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities. Other covered services are:

- Anesthesia
- Blood and blood products, and blood derivatives
- Drugs administered during treatment
- General nursing care
- Laboratory and diagnostic imaging services
- Other diagnostic or treatment related outpatient services
- Physician and other professional medical and surgical services provided while an outpatient
- Physical therapy
- Radiation therapy
- Rehabilitative and habilitative services

Healthcare Provider Office, Clinic or e-Visits

In addition to the office visit, benefits are available for (but not limited to) the following covered services when medically necessary:

- Allergy testing (based on established medical policies) and treatment, including injections
- Blood and blood products, and blood derivatives
- Diagnosis and treatment of illness or injury to the eyes (initial evaluation, lenses and fitting for contact or eyeglass lenses when prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconous)
- Professional medical and surgical services and related supplies from physicians and other health care providers
- All other injections
- Web-based e-Visits, telemedicine consultations or scheduled telephone visits.

Preventive and Wellness Services

Under the Affordable Care Act, many routine preventive services are fully (100 percent) covered and your deductible does not apply, as long as you use network benefits. Those services are:

- Routine health exams and periodic health assessments. A physician or healthcare provider will counsel you as to how often health assessments are needed based on your age, gender and health status.
- Child health supervision services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
- Routine prenatal services and exams to include visit-

specific screening tests, education and counseling.

- Routine postnatal services and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
- Routine screening procedures for cancer, including colorectal cancer, breast cancer and cervical cancer.
- Routine eye and hearing exams for children age 21 and under.
- Professional voluntary family planning services.
- Adult immunizations.
- Women's preventive health services, including mammograms, BRCA testing and genetic counseling for women who are at higher risk, screenings for cervical cancer, breast pumps, human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling (see prescription drug services section for coverage of contraceptive drugs).
- Obesity screening, counseling and management for all ages during a routine preventive care exam. If you are an adult age 18 or older and have a body mass index (BMI) of 30 or more, we also cover intensive obesity management to help you lose weight. Your primary care doctor can coordinate these services.

A detailed listing of preventive services provided at no cost share for adults, women and children is provided on page 11.

Behavioral Health Services

Benefits are available for medically necessary professional mental health services for evaluation, crisis intervention and treatment of mental health disorders for individuals, groups and families. A diagnostic assessment by a mental health professional will include recommendations regarding appropriate inpatient or outpatient treatment and services. Coverage also includes medically necessary services for assessments for the diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the appropriate state agency.

Transplant Services

Benefits are available for services associated with medically-necessary organ and tissue transplant, including, but not limited to, kidney, cornea, heart, lung, heart-lung, pancreas and pancreas-kidney. Benefits also are available for bone marrow transplants, including allogeneic and autologous stem cell transplants. Charges for transplant services must be incurred at a designated transplant center to receive in-network benefits. Donor medical and hospital expenses are covered only when the recipient is covered under the Policy and the transplant and directly-related donor expenses have received prior authorization for coverage. Medical complications experienced by the donor are not covered if they are not a member on the Policy.

Home Health Services

Benefits are available for skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services for newborns (including supplies and equipment), home health aide services and other eligible home health services when provided in your home, if you are homebound (i.e., unable to leave home without considerable effort due to a medical condition; lack of transportation does not constitute homebound status).

We cover palliative care benefits, including symptom management, education and establishing goals of care. The requirement that you be homebound for a limited number of home visits for palliative care (as shown in the schedule of payments) is waived if you have a life-threatening, non-curable condition that has a prognosis of survival of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

Total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy also are covered. IV line care kits are covered under Durable Medical Equipment. You do not need to be homebound to receive TPN/IV therapy.

Hospice Services

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice services include in-patient services (through a hospice facility), home health services (part-time or continuous care, as medically necessary) from an interdisciplinary hospice team (physician, nurse, social worker and/or spiritual counselor), as well as respite care. Medically necessary medications for pain and symptom management, semi-electric hospital beds and other durable medical equipment, and emergency and non-emergency care may also be covered.

Emergency and Urgently Needed Care Services

Coverage is provided for emergency care to treat the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or a condition requiring professional health services immediately necessary to preserve life or stabilize health. Urgently needed care are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration of your health, and which cannot be delayed until the next available clinic or office hours.

Other Covered Services

Refer to the Individual Policy and Benefits Chart for a complete description of other covered services. A brief summary includes:

- Ambulance and medical transportation services
- Durable medical equipment, prosthetics, orthotics and supplies
- Health education for preventive services and education for the management of chronic health problems
- Laboratory services when ordered by a provider
- Accidental, medical referral dental services, oral surgery; treatment of cleft lip and cleft palate of a dependent child
- Mastectomy reconstruction including lymphedemas
- Non-surgical musculoskeletal treatment of ailments to the musculoskeletal system such as manipulations or related procedures
- Pediatric eyewear for children age 18 and under
- Physical therapy, occupational therapy and speech therapy services when medically necessary to correct effects of illness or injury, or habilitative care rendered for congenital, developmental or medical conditions
- Temporomandibular Disorder (TMD) (benefit period maximums apply)

Important Terms to Know

Calendar Year Deductible: The deductible is the fixed dollar amount you pay for covered services each calendar year before benefits are available. There are individual and family deductibles.

Family Deductible: The family deductible is equal to two times the individual deductible for in-network covered services unless otherwise indicated on your benefits chart. When a plan covers more than one person in a family, the benefits will begin for a family member once the family member meets the individual deductible.

Copayment and Coinsurance: For some services, you are responsible for paying a copayment until you reach your out-of-pocket maximum. For other services, you must meet your deductible before coverage begins. Once you meet your calendar year deductible, you are responsible for paying copayments or a certain percentage of your covered charges (coinsurance) until you reach your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you pay nothing for covered services for the rest of the calendar year. Copayment amounts for office visits and prescription drugs apply toward your out-of-pocket maximum.

Please refer to the charts on pages 4 and 5 to determine the deductible and coinsurance amounts. Covered services or items requiring a copayment or coinsurance are specified in the Individual Policy. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

Allowed Amount: For covered services delivered by participating network providers, allowed amount is the provider's negotiated charge for a given medical/surgical service, procedure or item.

The allowed amount for covered services provided by a non-network provider will be based on the lesser of (either) billed charges, a percentage of billed charges or a usual and customary fee based on national and regional source data. Allowed amount will not exceed the billed charge.

A charge is incurred for covered ambulatory medical and surgical services, on the date the service or item is provided. A charge is incurred for covered inpatient services, on the date of admission to a hospital. To be covered, a charge must be incurred on or after your effective date and on or before the termination date.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to the monthly premium payments.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100 percent of the allowed amount for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded. Non-network benefits above the allowed amount (see definition of allowed amount above) do not apply to the out-of-pocket limit.

Qualified Health Plan: CoOportunity Premier is a health plan that has been certified by the Nebraska Health Insurance Marketplace (Exchange), provides essential health benefits, follows established limits on cost-sharing and meets other requirements defined in the Affordable Care Act.

Preventive Services Covered with No Cost-Sharing

The Affordable Care Act requires that private insurers cover certain preventive services without any patient cost-sharing. This summary of selected preventive services provides a listing of services that are covered by all CoOportunity Premier plans without your having to pay a copayment or coinsurance or meet your deductible. This applies only when these services are delivered by an in-network provider. For a complete description of preventive services, refer to the Individual Policy and/or Benefits Chart provided when you enroll in a plan. Visit coOportunityhealth.com/PreventiveCare for more information.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm:** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse:** screening and counseling
- **Aspirin:** use for men and women of certain ages
- **Blood Pressure:** screening for all adults
- **Cholesterol:** screening for adults of certain ages or at higher risk
- **Colorectal Cancer:** screening for adults over 50
- **Depression:** screening for adults
- **Type 2 Diabetes:** screening for adults with high blood pressure
- **Diet:** counseling for adults at higher risk for chronic disease
- **HIV:** screening for all adults at higher risk
- **Immunization:** vaccines for adults — doses, recommended ages, and recommended populations vary; an immunizations and vaccine schedule is provided upon request.
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Meningococcal
  - Pneumococcal
  - Varicella
  - Herpes Zoster
  - Tetanus, Diphtheria, Pertussis
  - Measles, Mumps, Rubella
- **Lung Cancer:** screenings
- **Obesity:** screening and counseling for all adults
- **Sexually Transmitted Infection (STI):** prevention counseling for adults at higher risk
- **Tobacco Use:** screening for all adults and cessation interventions for tobacco users
- **Syphilis:** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia:** screening on a routine basis for pregnant women
- **Bacteriuria:** urinary tract or other infection screening for pregnant women
- **BRCA:** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography:** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention:** counseling for women at higher risk
- **Breast Cancer Medication:** for primary breast cancer prevention
- **Breastfeeding:** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer:** screening for sexually active women
- **Chlamydia Infection:** screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic and interpersonal violence:** screening and counseling for all women
- **Folic Acid:** supplements for women who may become pregnant
- **Gestational diabetes:** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea:** screening for all women at higher risk
- **Hepatitis B:** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV):** screening and counseling for sexually active women
- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis:** screening for women over age 60 depending on risk factors
- **Rh Incompatibility:** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use:** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI):** counseling for sexually active women
- **Syphilis:** screening for all pregnant women or other women at increased risk
- **Well-woman visits:** to obtain recommended preventive services

Covered Preventive Services for Children

- **Alcohol and Drug Use:** assessments for adolescents
- **Autism:** screening for children at 18 and 24 months
- **Behavioral assessments for children of all ages:** 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Blood Pressure:** screening for children 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Cervical Dysplasia:** screening for sexually active females
- **Congenital Hypothyroidism:** screening for newborns
- **Depression:** screening for adolescents
- **Developmental screening** for children under age 3, and surveillance throughout childhood
- **Dyslipidemia screening** for children at higher risk of lipid disorders; ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Fluoride Chemoprevention supplements** for children without fluoride in their water source
- **Gonorrhea:** preventive medication for the eyes of all newborns
- **Hearing:** screening for all newborns
- **Height, Weight and Body Mass Index measurements** for children ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Hematocrit or Hemoglobin:** screening for children
- **Hemoglobinopathies or sickle cell screening** for newborns
- **HIV screening** for adolescents at higher risk
- **Immunization vaccines** for children — doses, recommended ages, and recommended populations vary; an immunizations and vaccine schedule is provided upon request.
  - Hepatitis A
  - Hepatitis B
  - Inactivated Poliovirus
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Varicella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Haemophilus influenzae type b
  - Tetanus, Diphtheria, Pertussis
  - Measles, Mumps, Rubella
- **Iron supplements** for children ages 6 to 1 2 months at risk for anemia
- **Lead screening** for children at risk of exposure
- **Medical History** for all children throughout development ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Obesity screening** and counseling
- **Oral Health risk assessment** for young children ages 0 to 11 months, 1 to 4 years, 5 to 10 years
- **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
- **Tuberculin testing** for children at higher risk of tuberculosis ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Vision screening** for all children

Notification Requirements

The following are requirements you or your CoOportunity Premier provider must follow to receive the maximum benefits available under your contract.

Summary of Health Management Programs

CoOportunity Health case and utilization management programs help ensure effective, accessible and high quality healthcare. These programs are based on the most up-to-date medical evidence to evaluate appropriate levels of care and establish guidelines for medical practices. Our programs include activities to reduce the underuse, overuse and misuse of healthcare services. These programs include:

- Inpatient care coordination to support timely care and ensure a safe and timely transition from the hospital
- Complex case management to provide care coordination
- The CareCheck® program to coordinate out-of-network hospitalizations and certain services.

In Network Inpatient Hospital Admissions

CoOportunity Health must be notified of all non-maternity inpatient hospital admissions. This enables us to coordinate discharge planning, case management and disease management services with our patient providers. If the patient is hospitalized in a contracting Midlands Choice Premier hospital in Nebraska, notification will be provided by the hospital. If the patient is hospitalized in a non-network hospital in Nebraska, or is admitted to an inpatient facility in another state, CoOportunity Health must be notified by you or your provider.

Your Policy provides coverage for services from a network of participating providers and facilities (physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies) with which CoOportunity Health has contractual agreements. A current list of network physicians, providers or facilities that are authorized to provide certain covered services as described in the Individual Policy. To obtain network benefits for covered services, you must receive services from your network providers. There are limited exceptions as described in the Policy. You can view a provider directory at any time by logging on to **coOportunityhealth.com/ProviderSearch**. You also may call Member Services and request a paper copy.

Out of Network Services

You must call CareCheck® at 1.800.316.9807 to receive maximum benefits when using out-of-network providers for inpatient hospital stays: same-day surgery; new or experimental or reconstructive outpatient technologies or procedures: durable medical equipment or prosthetics costing more than $3,000; home health services after your visits exceed 30; and skilled nursing facility stays. We will review your proposed treatment plan, determine length of stay, approve additional days when needed and review the quality and appropriateness of the care you receive. Benefits will be reduced by 20 percent if CareCheck® is not notified.

Prior Approvals

We require prior approval for a small number of services and procedures. For a complete list, go to **coOportunityhealth.com/MedicalPolicies** or call Member Services toll-free at 1.888.324.2064.

Limitations & Exclusions

In addition to any other benefit exclusions, limitations or terms, CoOportunity Premier health plans will not cover charges incurred for any of the following services:

- **Pediatric dental services: this plan does not include pediatric dental services as required under the ACA. This coverage is available on the Nebraska Health Insurance Marketplace and can be purchased as stand-alone coverage.**
- Treatment, procedures or services or drugs that are not medically necessary and/or which are primarily educational in nature or for your vocation, comfort, convenience, appearance, or recreation, including skills training.
- Procedures, technologies, treatments, facilities, equipment, drugs and devices that are considered investigative, or otherwise not clinically accepted medical services. We consider vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and do not cover these services. We also consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in your Policy. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
- Rest and respite services and custodial care, except as respite services are specifically described in the Benefits Chart under the subsection "Hospice Services." This includes all services, medical equipment and drugs provided for such care.
- Halfway houses, extended care facilities, or comparable facilities, residential treatment services, except as specifically described in the Individual Policy and Benefits Chart.
- Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
- Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to medically necessary complications related to an excluded service if they would otherwise be covered under your Policy.
- Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
- Cosmetic surgery, cosmetic services and treatments primarily for the improvement of your appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for reconstructive surgery.
- Dental treatment, procedures or services not listed in your Individual Policy and Benefits Chart.
- Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
- Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
- Court ordered treatment.
- Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) intracytoplasmic sperm injection (ICSI), and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility, including but not limited to, office visits, laboratory and diagnostic imaging services; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage; however, we do cover office visits and consultations to diagnose infertility.

- Services and/or surgery for gender reassignment, unless determined medically necessary.
- Routine foot care, unless the services meet our criteria for medically necessary care.
- Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this Policy. This exclusion does not apply to pediatric eyewear or cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or logging on to **coOportunityhealth.com/MedicalPolicies**.
- Medical food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula. This exclusion does not apply to oral amino acid based elemental formula if it meets our medical coverage criteria.
- Genetic counseling and genetics studies except when the results would influence a treatment or management of a condition or family planning decision. Our medical policies (medical coverage criteria) are available by calling Member Services, or logging on to **coOportunityhealth.com/MedicalPolicies**.
- Services provided by a family member of the enrollee, or a resident in the enrollee's home.
- Religious counseling; marital/relationship counseling and sex therapy.
- Private duty nursing services.
- Services that are provided to you, if you also have other primary insurance coverage for those services and you do not provide us the necessary information to pursue Coordination of Benefits, as required under your Policy.
- For non-network benefits, the portion of a billed charge for an otherwise covered service by a provider, which is in excess of the allowed amount. We also do not cover charges or a portion of a charge that is either a duplicate charge for a service or charges for a duplicate service.
- Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which you are not obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the insured, except in cases of undue financial hardship.
- Provider and/or insured travel and lodging incidental to travel, regardless if it is recommended by a physician.
- Health club memberships.
- Elective abortions, except in situations where the life of the mother would be endangered if the fetus is carried to full term.
- Massage therapy.
- Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
- Autopsies.
- Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond 12 months from the date of the injury, (4) received beyond the initial treatment or restoration, or (5) received beyond twenty-four months from the date of injury.
- Nonprescription (over the counter) drugs or medications, unless listed on the drug list and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. We cover off-label use of drugs to treat HIV/AIDS and cancer as specified in the "Prescription Drug Services" section of this Policy. The drug list is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies. The drug list is available by calling Member Services, or logging on to **coOportunityhealth.com/DrugList**. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Insured obtains a prescription for the item.
- Non-medical administrative fees and charges including but not limited to medical record preparation charges, appointment cancellation fees, after hours appointment charges and interest charges.
- Charges for sales tax.
- Charges for elective home births.
- Professional services associated with substance abuse interventions. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this Policy to seek substance abuse treatment.

- Services provided by naturopathic providers.
- Oral surgery to remove wisdom teeth.
- Acupuncture.
- Biofeedback, except as specified in the Benefits Chart.
- All drugs used for sexual dysfunction.
- All drugs used for the treatment of infertility.
- Orthognathic treatment or procedures and all related services.
- Commercial weight loss programs and exercise programs, and all weight loss/bariatric surgery.
- Treatment, procedures, or services or drugs which are provided when you are not covered under your Policy.
- Routine eye exams for adults age 22 and older.
- Routine hearing exams for adults age 22 and older.
- Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including Applied Behavioral Analysis (ABA), Intensive Early Intervention using Behavioral Therapy (IEIBT) and Lovaas.

Important Information

Protecting Your Privacy and Personal Health Information

CoOportunity Health complies with federal and state laws regarding the confidentiality of medical records and personal information about our members. Our policies and procedures help ensure that the collection, use and disclosure of information complies with the law. When needed, we get consent and authorization from our members (or an approved member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable laws and standards. Our policies and practices support appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, while being sensitive to privacy. For a copy of our Notice of Privacy Practices, please visit **coOportunityhealth.com** or call Member Services toll-free at 1.888.324.2064.

Read your policy carefully

This Outline of Coverage provides you with a brief description of CoOportunity Premier plan features and coverage. This is not your policy. Only the actual benefit provisions in your policy determine your benefits. The policy details your rights and obligations, as well as CoOportunity Health's rights and obligations. In the event discrepancies arise with the information in this document, the terms and conditions of your policy will govern. Therefore, it is important that you read your policy carefully.

For more complete information about this health plan, including benefits, exclusions and limitations, please refer to the CoOportunity Premier Individual Policy and Benefits Chart, which will be available when you become an enrolled member.

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Connect with us

If you need assistance selecting a plan or have questions, call our Individual Sales Hotline toll-free at 1.866.217.6111, Mon–Fri, 8 a.m. – 6 p.m.

CoOportunity Health is a Qualified Health Plan issuer in the Nebraska Health Insurance Marketplace. CoOportunity Health does not discriminate on the basis of age, color, creed, disability, gender identity, health status, national origin, race, religion, sex or sexual orientation in the administration of its products and plans, including enrollment and benefit determinations. CoOportunity Health has contracted with HealthPartners Administrators, Inc. to provide claims processing, medical management and certain other administrative services.