PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Group Name: City of Omaha
Civilian AEC, CB, CMPTEC & Functional Retiree on or before 5/18/10

Effective Date: January 01, 2025

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered Services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network Allowance. All Covered Services must be Medically Necessary and may be subject to the Plan's medical criteria.		
In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit NebraskaBlue.com/Find-a-Doctor. For certain Durable Medical Equipment, Independent Laboratory and Specialty Drug Services, the Doctor Finder may display providers that are considered Out-of-network for these types of Services. Please refer to your benefit book for additional information.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Employee + 1 (Embedded*) • Family (Embedded*)	 $400 $800 $800	 $400 $800 $800
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays • Plan Pays	 20% 80%	 30% 70%
Medical Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays) • Individual • Employee + 1 (Embedded*) • Family (Embedded*)	 $1,000 $2,000 $2,000	 $1,000 $2,000 $2,000
In-network and Out-of-network Deductible and Out-of-pocket Limits cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently. Day, session or visit limits for certain services shown on this summary are not applicable to Mental Health and/or Substance Use Disorders. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		
Copayment(s) (copay(s)) apply to: • This plan has no medical copays		
Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits. For additional information regarding Preauthorization procedures please visit NebraskaBlue.com/PreAuth.		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office Services Primary Care Physician Office Visit, Specialist Physician Office Visit, and all other Covered Services and supplies provided in the Physician's office (with or without an office visit billed)	Deductible and Coinsurance	Deductible and Coinsurance
• Allergy Injections and Serum	Deductible and Coinsurance	Deductible and Coinsurance
• Other Injections	Deductible and Coinsurance	Deductible and Coinsurance
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. ***Specialist Physician*** is a physician who is not a Primary Care Physician. ***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) consultations and medication checks. ***Physician Office Services*** include but are not limited to: office visits; X-ray, laboratory and pathology services; Allergy Testing, Injections and Serums; Supplies and/or Drugs administered during the office visit; Hearing exams or Eye exams due to Illness or Injury excluding refractions. ***Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:*** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.		
Telehealth/Virtual Care Services • Medical • Mental Health	Deductible and Coinsurance See Mental Health and/or Substance Use Disorder Services	Not Covered Not Covered
Convenient Care/Retail Clinics (Quick Care)	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room Services (services received in a Hospital emergency room setting) • Facility • Professional Services	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See NebraskaBlue.com/PreferredCenters for a list of Covered Services and designated hospitals.		

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services • Covered Services billed as preventive such as physicals, laboratory, well baby care, well child care, well woman care, prostate cancer screening, certain osteoporosis screenings, hearing exams, cardiac stress tests and adult/child immunizations.	Plan Pays 100%	Plan Pays 100% of first $200, then subject to Deductible and Coinsurance, except Deductible is waived on pediatric immunizations up to age 7
• Routine Mammograms	Plan Pays 100%	Deductible and Coinsurance
• Routine Colonoscopies	Plan Pays 100%	Deductible and Coinsurance

Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth/Virtual Care Services	Deductible and Coinsurance	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Office Services include office visits, medication checks, psychological therapy and/or substance use disorder counseling, x-rays, laboratory tests, supplies and/or drugs administered during the office visit. ***Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items & Services.*** This includes but is not limited to: psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered Mental Health and/or Substance Use Disorder services.		
Emergency Room Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Autism Spectrum Disorder • Testing and Diagnosis • Treatment	 Same as mental health Same as mental health	 Same as mental health Same as mental health
Biofeedback • Medical • Mental Health	 Deductible and Coinsurance Same as mental health	 Deductible and Coinsurance Same as mental health
Dermatological Services	Deductible and Coinsurance	Deductible and Coinsurance
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other outpatient settings)	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Devices • Bone Anchored Hearing Aids • Cochlear Implants • Hearing aids (Only up to age 19 limited to $3,000 every 48 months)	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Home Health Aide, Skilled Nursing and Respiratory Care • Home Health Aide (limited to 60 days per Calendar Year) • Home Infusion Therapy • Skilled Nursing Care (limited to 8 hours per day) • Respiratory Care	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Independent Laboratory • Diagnostic	Deductible and Coinsurance	Deductible and Coinsurance
Infertility • Services to Diagnose • Treatment to Promote Fertility	Deductible and Coinsurance Not Covered	Deductible and Coinsurance Not Covered
Nicotine Addiction • Medical Services and Therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	Same as Substance Use Disorder Services Not Covered	Same as Substance Use Disorder Services Not Covered
Obesity • Non-Surgical Treatment • Surgical Treatment (limited to medically necessary treatment of morbid obesity)	Not Covered Deductible and Coinsurance	Not Covered Deductible and Coinsurance
Oral Surgery and Dentistry Services such as, impacted wisdom teeth, incision and drainage of abscesses, excision of tumors and cysts and bone grafts to the jaw. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions)	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
NOTE: Dependent child maternity is Not Covered, except for ACA preventive services included under https://healthcare.gov/preventive-care-women/. **NOTE:** The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.		
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per Calendar Year) • Pulmonary Rehabilitation (limited to 36 sessions per Calendar Year)	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Sterilization • Elective sterilization female • Elective sterilization male	 Plan Pays 100% Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy and manipulative treatments or adjustments (combined limit to 60 sessions per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Treatment limits stated for physical therapy, occupational therapy and speech therapy services are not applicable to treatment provided for Mental Health or Substance Use Disorders. Evaluations are covered and do not apply to the combined calendar year limit.		
Vision Services • Eyeglasses or Contact Lenses (Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury) must be within 12 month of surgery or injury Aphakic patients and soft lenses or sclera shells intended for use as corneal bandages • Vision Corrective Surgery • Vision Exam - Diagnostic (to diagnose an illness) - Preventive (routine exam including refraction) limited to one exam per calendar year	 Deductible and Coinsurance Not Covered See Physician Office Services Plan Pays 100%	 Deductible and Coinsurance Not Covered See Physician Office Services Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs CVS Caremark	In-network Provider	Out-of-network Provider
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance is applicable)	Individual/ Family $100	
Prescription Drug Out-of-Pocket Limit	Individual/Family: $850	
Retail – per 30-day supply		
• Generic Drugs (Including non-preferred contraceptives)	$5 Copay	Deductible + 50% Penalty
• Preferred Brand Name Drugs	20% Subject to $20 minimum/$40 Max.	Deductible + 50% Penalty
• Non-Preferred Brand Name Drugs	20% Subject to $30 minimum/$60 Max	Deductible + 50% Penalty
NOTE: Once the Out-of-Pocket Limited is reached, the Copay with be $5.		
Mail Order – per 90-day supply		
• Generic Drugs (Including non-preferred contraceptives)	$10 Copay	Not Covered
• Preferred Brand Name Drugs	20% Subject to $40 minimum/$80 Max.	Not Covered
• Non-Preferred Brand Name Drugs	20% Subject to $60 minimum/$120 Max.	Not Covered
NOTE: Once the Out-of-Pocket Limited is reached, the Copay continues to be $10.		
Specialty Drugs		
• Generic Drugs (Including non-preferred contraceptives)	$3.33 Copay	Not Covered
• Preferred Brand Name Drugs	20% Subject to $13.33 minimum/$26.67 Max.	Not Covered
• Non-Preferred Brand Name Drugs	20% Subject to $20 minimum/$40 Max.	Not Covered
NOTE: Once the Out-of-Pocket Limited is reached, the Copay continues to be $13.33 per 30 day supply.		

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.