PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Group Name: City of Omaha
Civilian AEC, CB, CMPTEC, FUNC Active, Retiree, COBRA on or after 5/19/2010
Fire Management Active, Retiree, COBRA on or after 5/19/2010

Effective Date: January 1, 2026

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 (BCBSNE) 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 Noncovered Services, which are the Covered Person's responsibility. That means In-network Providers, under the terms of their contract with BCBSNE, 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 locating In-network Providers, visit NebraskaBlue.com/DoctorFinder. 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. 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	$3,400	$6,800
• Employee + 1 (Embedded*)	$6,800	$13,600
• Family (Embedded*)	$6,800	$13,600
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
• Covered Person Pays	0%	30%
• Plan Pays	100%	70%
Medical Out-of-pocket Limit (Includes Deductible, Coinsurance and Copayments)		
• Individual	$3,400	$13,600
• Employee + 1 (Embedded*)	$6,800	$27,200
• Family (Embedded*)	$6,800	$27,200
In-network and Out-of-network Deductible and Out-of-pocket Limits cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) 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 Disorder Services. 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. 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 Limit.		
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 visit NebraskaBlue.com/PreAuth.**		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Primary Care Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Benefits for **Primary Care Physician** or **Specialist Physician office visit** include the **office visit** (including the initial visit to diagnose Pregnancy), consultations and medication checks.		
Allergy Testing, Injections and Serum	Deductible and Coinsurance	Deductible and Coinsurance
Other Injections	Deductible and Coinsurance	Deductible and Coinsurance
Physician Office Services	Deductible and Coinsurance	Deductible and Coinsurance
The following **Physician Office Services** are available when provided in a **Primary Care Physician or Specialist Physician's office,** with or without an **office visit;** X-rays, laboratory and pathology Services, allergy testing, injections and serums, supplies and/or drugs administered during the **office visit**, hearing exams or eye exams (excluding refractions) due to Illness or Injury. Other Services provided in the office but **NOT** included in the **Physician's office visit** or **Physician office Services** benefit listed above, include but are not limited to; **Preventive Services**, **Mental Health** and/or **Substance Use Disorder Services**, **Biofeedback**, **Advanced Diagnostic Imaging** (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine), **Durable Medical Equipment**, **Pregnancy, Maternity** and **Newborn Care**, **Radiation Therapy** and **Chemotherapy**, **Sleep Studies**, **Therapy** and **Manipulations** and Surgery and Anesthesia. *(Refer to the appropriate categories below and your benefit book for additional information.)*		
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 • 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 include but are not limited to surgery, laboratory and radiology, observation stays, and other Services provided on an Outpatient basis.	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Services include but are not limited to charges for room and board, diagnostic testing, rehabilitation Services 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: 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. • Routine Mammograms • Routine Colonoscopies	Plan Pays 100% Plan Pays 100% Plan Pays 100%	Employee Only: Plan Pays 100% of first $200, then subject to Deductible and Coinsurance Dependents: Not Covered Deductible and Coinsurance Deductible and Coinsurance
Immunizations • Pediatric (up to age 7) • Age 7 and older • Related to an illness	Plan Pays 100% Plan Pays 100% Deductible and Coinsurance	Not Covered See Preventive Services Deductible and Coinsurance
Mental Health and/or Substance Use Disorder Services	**In-network Provider**	**Out-of-network Provider**
Office Visit Benefits for **office visit** include the **office visit**, medication checks, psychological therapy and/or Substance Use Disorder counseling.	Deductible and Coinsurance	Deductible and Coinsurance
Office Services The following **office Services** are available when provided in the office; X-rays, laboratory tests, supplies and/or drugs administered during the **office visit**.	Deductible and Coinsurance	Deductible and Coinsurance
All Other Outpatient Items and Services Other Services provided in the office but **NOT** included in the **office visit** or **office Services** benefit listed above include, but are 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.	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth/Virtual Care Services	Deductible and Coinsurance	Not Covered
Emergency Room Services • Facility • Professional Services	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
For additional resources and support visit NebraskaBlue.com/MentalHealth		
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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Services • Bone Anchored Hearing Aids • Cochlear Implants • Hearing Aids and related Services (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 Care Services • Home Health Aide (limited to 60 days per Calendar Year) • Home Infusion Therapy • Respiratory Care • Skilled Nursing Care (limited to 8 hours per day)	 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
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 include but is not limited to Inpatient and Outpatient professional Services for 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 plans enrollment provisions)	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
NOTE: The plan pays 100% for the initial postpartum depression screening up to one year following a Pregnancy or childbirth. **NOTE:** Dependent child maternity is Not Covered, except for ACA preventive services included under https://healthcare.gov/preventive-care-women/.		

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
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
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 75 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 and/or Substance Use Disorder Services. Evaluations are covered but 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 due to intraocular surgery or ocular Injury, must be within 12 months of surgery or Injury) Aphakic patients and soft lenses or sclera shells intended for use as corneal bandages • Vision Correction Surgery (keratomileusis surgery or LASIK surgery for myopia or aphakic hyperopia for employee only) • Eye 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
Retail – per 30-day supply		
• Generic Drugs (Including non-preferred contraceptives)	100% after Deductible	70% after Deductible + 50% Penalty
• Preferred Brand Name Drugs	100% after Deductible	70% after Deductible + 50% Penalty
• Non-Preferred Brand Name Drugs	100% after Deductible	70% after Deductible + 50% Penalty
Home Delivery – per 90-day supply		
• Generic Drugs (Including non-preferred contraceptives)	100% after Deductible	Not Covered
• Preferred Brand Name Drugs	100% after Deductible	Not Covered
• Non-Preferred Brand Name Drugs	100% after Deductible	Not Covered
Specialty Drugs	100% after Deductible	Not Covered

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 limitations, refer to the Contract. In the event there are discrepancies between this document and the Contract, the terms and conditions of the Contract will govern.