

# PremierBlue

## Schedule of Benefits Summary

Group Name: City of Omaha  
 Police Bargaining Active, Retiree, COBRA on or after 9/19/10  
 Police Management Active, Retiree, COBRA on or after 5/19/10

Effective Date: January 01, 2024

| Payment for Services  | In-network Provider  | Out-of-network Provider   |
|---|--|---|
| <p>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.</p> |  |   |
| <p><b>In-network Provider:</b> <a href="http://NebraskaBlue.com/Find-a-Doctor">The provider network is shown on your I.D. card. For help in locating In-network Providers, visit NebraskaBlue.com/Find-a-Doctor.</a></p>  |  |   |
| <p><b>Deductible</b><br/>           (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Employee +1 (Embedded*)</li> <li>Family (Embedded*)</li> </ul>  | <p>\$3,200<br/>           \$6,400<br/>           \$6,400</p> | <p>\$6,400<br/>           \$12,800<br/>           \$12,800</p>  |
| <p><b>Coinsurance</b><br/>           (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> <li>Covered Person Pays</li> <li>Plan Pays</li> </ul>   | <p>0%<br/>           100%</p>                                | <p>30%<br/>           70%</p>                                   |
| <p><b>Out-of-pocket Limit</b><br/>           (Includes Deductible, Coinsurance and Copays)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Employee +1 (Embedded*)</li> <li>Family (Embedded*)</li> </ul>  | <p>\$3,200<br/>           \$6,400<br/>           \$6,400</p> | <p>\$12,800<br/>           \$25,600<br/>           \$25,600</p> |
| <p>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.</p>  |  |   |
| <p>*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.</p>   |  |   |
| <p><b>Copayment(s) (copay(s)) apply to:</b></p> <ul style="list-style-type: none"> <li>This plan has no medical copays</li> </ul>   |  |   |
| <p><b>Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits.</b></p>  |  |   |

| Covered Services – Illness or Injury   | In-network Provider  | Out-of-network Provider  |
|--|--|--|
| <b>Physician Office Services</b> <ul style="list-style-type: none"> <li>Primary Care Physician Office Visit</li> <li>Specialist Physician Office Visit</li> <li>Physician Office Services provided in the office (with or without an office visit)</li> </ul>  | Deductible and Coinsurance<br><br>Deductible and Coinsurance<br><br>Deductible and Coinsurance | Deductible and Coinsurance<br><br>Deductible and Coinsurance<br><br>Deductible and Coinsurance |
| <ul style="list-style-type: none"> <li>Allergy Injections and Serum</li> </ul>   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <ul style="list-style-type: none"> <li>Other Injections</li> </ul>   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <p><b>Primary Care Physician</b> 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 <b>physician assistant</b> is covered in the same manner as a Primary Care Physician.</p> <p><b>Specialist Physician</b> is a physician who is not a Primary Care Physician.</p> <p><b>Office Visit Benefits</b> for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) consultations and medication checks.</p> <p><b>Physician Office Services</b> 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.</p> <p><b>Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:</b> 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.</p> |  |  |
| <b>Telehealth/Virtual Care Services</b> <ul style="list-style-type: none"> <li>Medical</li> <li>Mental Health</li> </ul>   | Deductible and Coinsurance<br>See Mental Health and/or Substance Use Disorder Services         | Not Covered<br><br>Not Covered   |
| <b>Convenient Care/Retail Clinics (Quick Care)</b>   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>Urgent Care Facility Services</b>   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>Emergency Room Services</b> (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul>  | Deductible and Coinsurance<br>Deductible and Coinsurance                                       | In-network level of benefits<br>In-network level of benefits                                   |
| <b>Outpatient Hospital or Facility Services</b><br>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   |
| <b>Inpatient Hospital or Facility Services</b><br>Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>Orthopedic Specialty Hospital or Facility Services</b>  | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>NOTE:</b> Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See <a href="http://NebraskaBlue.com/PreferredCenters">NebraskaBlue.com/PreferredCenters</a> for a list of Covered Services and designated hospitals.  |  |  |

| <b>Preventive Services</b>   | <b>In-network Provider</b>   | <b>Out-of-network Provider</b>  |
|--|--|---|
| <b>Preventive Services</b> <ul style="list-style-type: none"> <li>Covered Services billed as preventive such as physicals, laboratory, well baby care, well child care, well woman care, prostate cancer screenings, hearing exams, cardiac stress tests and adult/child immunizations</li> <li>Routine Mammograms</li> <li>Routine Colonoscopies</li> </ul> | Plan Pays 100%<br><br>Plan Pays 100%<br><br>Plan Pays 100%             | Employee Only: Plan Pays 100% of first \$175, then subject to Deductible and Coinsurance<br><br>Dependents: Not Covered<br><br>Deductible and Coinsurance<br><br>Deductible and Coinsurance |
| <b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>   | Plan Pays 100%<br><br>Plan Pays 100%<br><br>Deductible and Coinsurance | Not Covered<br><br>See Preventive Services<br><br>Deductible and Coinsurance  |

| <b>Mental Health and/or Substance Use Disorder Services</b>   | <b>In-network Provider</b>   | <b>Out-of-network Provider</b>  |
|---|--|---|
| <b>Inpatient Services</b>   | Deductible and Coinsurance   | Deductible and Coinsurance  |
| <b>Outpatient Services</b> <ul style="list-style-type: none"> <li>Office Services</li> <li>Telehealth/Virtual Care Services</li> <li>All Other Outpatient Items &amp; Services</li> </ul>   | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br>Not Covered<br>Deductible and Coinsurance |
| <p><b>Office Services</b> 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.</p> <p><b>Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items &amp; Services.</b> 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.</p> |  |   |
| <b>Emergency Care Services</b> (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul>   | Deductible and Coinsurance<br>Deductible and Coinsurance                               | In-network level of benefits<br>In-network level of benefits            |

| <b>Other Covered Services – Illness or Injury</b>  | <b>In-network Provider</b>                                   | <b>Out-of-network Provider</b>                                   |
|--|--|--|
| <b>Acupuncture</b>   | Not Covered  | Not Covered  |
| <b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)   | Deductible and Coinsurance                                   | Deductible and Coinsurance                                       |
| <b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground Ambulance</li> <li>• Air Ambulance</li> </ul>            | Deductible and Coinsurance<br><br>Deductible and Coinsurance | In-network level of benefits<br><br>In-network level of benefits |
| <b>Autism Spectrum Disorder</b> <ul style="list-style-type: none"> <li>• Testing and Diagnosis</li> <li>• Treatment</li> </ul>   | Same as mental health<br>Same as mental health               | Same as mental health<br>Same as mental health                   |
| <b>Biofeedback</b>   | Deductible and Coinsurance                                   | Deductible and Coinsurance                                       |
| <b>Dermatological Services</b>   | Deductible and Coinsurance                                   | Deductible and Coinsurance                                       |
| <b>Diabetic Services</b><br>Services include education, self-management training, podiatric appliances and equipment.  | Deductible and Coinsurance                                   | Deductible and Coinsurance                                       |
| <b>Drugs Administered in an Outpatient Setting</b><br>(such as home, physician office and other outpatient settings)   | Deductible and Coinsurance                                   | Deductible and Coinsurance                                       |
| <b>Durable Medical Equipment and Supplies (including Prosthetics)</b><br>(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  |
|--|--|--|
| <b>Hearing Services</b> <ul style="list-style-type: none"> <li>Bone Anchored Hearing Aids</li> <li>Cochlear Implants</li> <li>Hearing Aids (Only up to age 19, limited to \$3,000 every 48 months.)</li> </ul>   | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance                               | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance                               |
| <b>Home Health Aide, Skilled Nursing and Respiratory Care</b> <ul style="list-style-type: none"> <li>Home Health Aide (limited to 60 days per Calendar Year)</li> <li>Home Infusion Therapy</li> <li>Skilled Nursing Care (limited to 8 hours per day)</li> <li>Respiratory Care</li> </ul>          | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance |
| <b>Hospice Services</b> (limited to 180 days while covered under the Plan)   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>Diagnostic</li> </ul>   | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>Infertility</b> <ul style="list-style-type: none"> <li>Services to Diagnose</li> <li>Treatment to Promote Fertility</li> </ul>  | Deductible and Coinsurance<br>Not Covered  | Deductible and Coinsurance<br>Not Covered  |
| <b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical Services and Therapy</li> <li>Nicotine addiction classes &amp; alternative therapy, such as acupuncture</li> </ul>  | Same as Substance Use Disorder Services<br><br>Not Covered   | Same as Substance Use Disorder Services<br><br>Not Covered   |
| <b>Obesity</b> <ul style="list-style-type: none"> <li>Non-Surgical Treatment</li> <li>Surgical Treatment</li> </ul>  | Not Covered<br>Deductible and Coinsurance  | Not Covered<br>Deductible and Coinsurance  |
| <b>Oral Surgery and Dentistry</b><br>Services such as incision and drainage of abscesses and excision of tumors and cysts.<br>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   |
| <b>Organ and Tissue Transplantation</b>  | Deductible and Coinsurance   | Deductible and Coinsurance   |
| <b>Ostomy Supplies</b>   | Deductible and Coinsurance   | Deductible and Coinsurance   |

| Other Covered Services – Illness or Injury  | In-network Provider        | Out-of-network Provider    |
|---|----------------------------|----------------------------|
| <b>Physician Professional Services</b><br>Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services  | Deductible and Coinsurance | Deductible and Coinsurance |
| <b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>• Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>• Newborn care (Newborns are covered at birth, subject to the plan’s enrollment provisions)</li> </ul> | Deductible and Coinsurance | Deductible and Coinsurance |
| <b>NOTE:</b> Dependent child maternity is Not Covered.  |                            |                            |
| <b>NOTE:</b> The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.   |                            |                            |
| <b>Radiation Therapy and Chemotherapy</b>   | Deductible and Coinsurance | Deductible and Coinsurance |
| <b>Radiology (X-ray) Services and Other Diagnostic Tests</b>  | Deductible and Coinsurance | Deductible and Coinsurance |
| <b>Rehabilitation Services – Inpatient Facility</b>   | Deductible and Coinsurance | Deductible and Coinsurance |
| <b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation (limited to 18 sessions per Calendar Year)</li> <li>• Pulmonary Rehabilitation (limited to 36 sessions per Calendar Year)</li> </ul>   | Deductible and Coinsurance | Deductible and Coinsurance |
| <b>Renal Dialysis</b>   | Deductible and Coinsurance | Deductible and Coinsurance |

| <b>Other Covered Services – Illness or Injury</b>   | <b>In-network Provider</b>  | <b>Out-of-network Provider</b>  |
|---|---|---|
| <b>Sexual Dysfunction</b>   | Not Covered   | Not Covered   |
| <b>Skilled Nursing Facility</b><br>(limited to 60 days per Calendar Year)   | Deductible and Coinsurance  | Deductible and Coinsurance  |
| <b>Sleep Studies</b>  | Deductible and Coinsurance  | Deductible and Coinsurance  |
| <b>Sterilization</b> <ul style="list-style-type: none"> <li>Female</li> <li>Male</li> </ul>   | Plan Pays 100%<br>Deductible and Coinsurance  | Deductible and Coinsurance<br>Deductible and Coinsurance  |
| <b>Temporomandibular and Craniomandibular Joint Disorder</b>  | Deductible and Coinsurance  | Deductible and Coinsurance  |
| <b>Therapy &amp; Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy and manipulative treatments or adjustments (combined limit to 75 sessions per Calendar Year)</li> </ul>  | Deductible and Coinsurance  | Deductible and Coinsurance  |
| <b>Note:</b> 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.  |   |   |
| <b>Vision Services</b> <ul style="list-style-type: none"> <li>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<br/>Aphakic patients and soft lenses or sclera shells intended for use as corneal bandages</li> <li>Vision Correction Surgery (keratomileusis surgery or LASIK surgery for myopia or aphakic hyperopia for employee only)</li> <li>Vision Exam <ul style="list-style-type: none"> <li>Diagnostic (to diagnose an illness)</li> <li>Preventive (routine exam including refraction) limited to one exam per calendar year</li> </ul> </li> </ul> | Deductible and Coinsurance<br><br>Deductible and Coinsurance<br><br>See Physician Office Services<br><br>Plan Pays 100% | Deductible and Coinsurance<br><br>Deductible and Coinsurance<br><br>See Physician Office Services<br><br>Deductible and Coinsurance |
| <b>Wigs</b>   | Not Covered   | Not Covered   |
| <b>All Other Covered Services</b>   | Deductible and Coinsurance  | Deductible and Coinsurance  |

| <b>Prescription Drugs<br/>CVS Caremark</b>  | <b>In-network<br/>Provider</b>  | <b>Out-of-network<br/>Provider</b>   |
|---|---|--|
| <b><i>Retail – per 30-day supply</i></b> <ul style="list-style-type: none"> <li>• Generic Drugs (Including non-preferred contraceptives)</li> <li>• Preferred Brand Name Drugs</li> <li>• Non-preferred Brand Name Drugs</li> </ul>     | 100% after Deductible<br><br>100% after Deductible<br><br>100% after Deductible | 70% after Deductible + 50% Penalty<br><br>70% after Deductible + 50% Penalty<br><br>70% after Deductible + 50% Penalty |
| <b><i>Mail Order – per 90-day supply</i></b> <ul style="list-style-type: none"> <li>• Generic Drugs (Including non-preferred contraceptives)</li> <li>• Preferred Brand Name Drugs</li> <li>• Non-preferred Brand Name Drugs</li> </ul> | 100% after Deductible<br><br>100% after Deductible<br><br>100% after Deductible | Not Covered<br><br>Not Covered<br><br>Not Covered  |
| <b><i>Specialty Drugs</i></b>   | 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 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.