## **PremierBlue**



## Schedule of Benefits Summary

Group Name: City of Omaha Effective Date: January 1, 2026

Police Bargaining Active, Retiree, COBRA on or after 9/19/10 Police Management Active, Retiree, COBRA on or after 5/19/10

## 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.

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Deductible		
(the amount the Covered Person pays each Calendar		
Year for Covered Services before the Coinsurance is		
payable)		
<ul> <li>Individual</li> </ul>	\$3,400	\$6,800
<ul> <li>Employee + 1 (Embedded*)</li> </ul>	\$6,800	\$13,600
<ul> <li>Family (Embedded*)</li> </ul>	\$6,800	\$13,600
Coinsurance		
(the percentage amount the Covered Person must pay		
for most Covered Services after the Deductible has		
been met)		
<ul> <li>Covered Person Pays</li> </ul>	0%	30%
Plan Pays	100%	70%
Medical Out-of-pocket Limit		
(Includes Deductible, Coinsurance and Copayments)		
Individual	\$3,400	\$13,600
<ul> <li>Employee + 1 (Embedded*)</li> </ul>	\$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 <b>Primary Care Physician</b> or <b>Specialist Physician office visit</b> include the <b>office visit</b> (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		
<ul> <li>Medical</li> </ul>	Deductible and Coinsurance	Not Covered
Mental Health	See Mental Health and/or Substance Use Disorder Services	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		
<ul> <li>Facility</li> </ul>	Deductible and Coinsurance	In-network level of benefits
<ul> <li>Professional Services</li> </ul>	Deductible and Coinsurance	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
<b>NOTE:</b> Coinsurance may be waived if Covered Services	s are provided at a designated Preferred Ce	nter. See

**NOTE:** Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See <a href="NebraskaBlue.com/PreferredCenters">NebraskaBlue.com/PreferredCenters</a> for a list of Covered Services and designated Hospitals.

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Preventive Services  Covered Services billed as preventive such as physicals, laboratory, well baby care, well child care, well woman care, prostate cancer screening, charing exams, cardiac stress tests.  Routine Mammograms  Routine Mammograms  Routine Mammograms  Routine Mammograms  Plan Pays 100%  Pediotric (up to age 7)  Age 7 and older  Pediotric (up to age 7)  Age 7 and older  Pelan Pays 100%  Pelan Pays 1	Preventive Services	In-network Provider	Out-of-network Provider
Covered Services billed as preventive such as physicials, laboratory, well baby care, well child care, well woman care, prostate cancer screening, centain osteoporosis screenings, hearing exams, cardiac stress tests.      Routine Mammograms     Plan Pays 100%     Plan Pays	Preventive Services		
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well child care, well woman care, prostate cancer screening, shearing exams, cardiac stress tests.  • Routine Mammagrams  • Routine Mammagrams  • Padatric (up to age 7)  • Age 7 and older  • Pelan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Pelan Pays 100%  • Pelan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pelan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pelan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pelan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pelan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pelan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Pediatric (up to age 7)  • Age 7 and older  • Plan Pays 100%  • Deductible and Coinsurance  Deductible and Coinsurance  In-network Provider  Use Disorder Services  • Deductible and Coinsurance  In-network Provider  Area (and pays 1)  In-network Provider  Acupent Provider  Acupent Provider  • Professional Services  Deductible and Coinsurance  In-network level of benefits  In			
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Routine Mammograms	screenings, hearing exams, cardiac stress		D 1 . N . O 1
Routine Colonoscopies   Plan Pays 100%   Deductible and Coinsurance	tests.		•
Immunizations   Pediatric (up to age 7)		Plan Pays 100%	
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Plan Pays 100% See Preventive Services	<ul> <li>Pediatric (up to age 7)</li> </ul>	Plan Pays 100%	Not Covered
Related to an illness	· -		See Preventive Services
Mental Health and/or Substance   Deductible and Coinsurance   Deductible	· ·	•	
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Office Visit         Deductible and Coinsurance         Deductible and Coinsurance           Benefits for office visit include the office visit, medication checks, psychological therapy and/or Substance Use Disorder counseling.         Deductible and Coinsurance         Deductible and Coinsurance           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         Deductible and Coinsurance         Deductible and Coinsurance           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.           Telehaelth/Yitrual Care Services         Deductible and Coinsurance         Not Covered           Emergency Room Services         Deductible and Coinsurance         In-network level of benefits           Inpatient Services         Deductible and Coinsurance         In-network level of benefits           Inpatient Services - Illness or Injury         In-network Mental Health         Deductible and Coinsurance           Other Covered Services - Illness or Injury         In-network Provider         Not Covered           Acupuncture         Not Covered         Not Covered		In-network Provider	Out-of-network Provider
Benefits for office visit include the office visit, medication checks, psychological therapy and/or Substance Use Disorder counseling.   Office Services Provided In the office, X-rays, laboratory tests, supplies and/or drugs administered during the office visit.   All Other Outpatient Items and Services   Deductible and Coinsurance		Doductible and Coincurance	Doductible and Coincurance
Office Services         Deductible and Coinsurance         Deductible and Coinsurance           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         Deductible and Coinsurance         Deductible and Coinsurance         Deductible and Coinsurance           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.           Telehaelth/Virtural Care Services         Deductible and Coinsurance         Not Covered           Emergency Room Services         Deductible and Coinsurance         In-network level of benefits         In-network level of benefits           Inpatient Services         Deductible and Coinsurance         In-network level of benefits         In-network level of benefits           Inpatient 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           • Ground Ambulance			
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Other Services provided in the office but NOT included in the office Vest 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.  Telehealth/Virtual Care Services  Facility Peductible and Coinsurance Professional Services Peductible and Coinsurance Professional Services Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance For additional resources and support visit NebraskaBlue.com/MentalHealth  Other Covered Services—Illness or Injury In-network Provider  Acupuncture Acupuncture Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine) Ground Ambulance (to the nearest facility for appropriate care)  Ground Ambulance Arism Spectrum Disorder Testing and Diagnosis Same as Mental Health Deductible and Coinsurance		Deductible and Coincurance	Deductible and Coincurance
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Mental Health and/or Substance Use Disorder Services   Deductible and Coinsurance   Not Covered			
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Emergency Room Services Facility Professional Services Deductible and Coinsurance Professional Services Deductible and Coinsurance			Not Covered
Professional Services  In-network level of benefits Inpatient Services  Deductible and Coinsurance  For additional resources and support visit NebraskaBlue.com/MentalHealth  Other Covered Services - Illness or Injury In-network Provider  Acupuncture  Acupuncture  Acupuncture  Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)  Ambulance (to the nearest facility for appropriate care)  For Ground Ambulance For Admulance For Admulance For Admulance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance For Admulance For Adm		Deductible and Comsulance	NOT COVERED
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Other Covered Services - Illness or Injury   In-network Provider   Out-of-network Provider			
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Acupuncture Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)  Ambulance (to the nearest facility for appropriate care)  • Ground Ambulance • Air Ambulance • Testing and Diagnosis • Treatment  Biofeedback • Medical • Medical • Mental Health  Dematological Services  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  In-network level of benefits  In-network level of benefits  Same as Mental Health  Deductible and Coinsurance			
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)  Ambulance (to the nearest facility for appropriate care)  Ground Ambulance  Air Ambulance  Air Ambulance  Testing and Diagnosis  Treatment  Biofeedback  Medical  Medical  Mental Health  Dematological Services  Diabetic Services  Diabetic Services  Deductible and Coinsurance	Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
MRS, PET & SPECT scans and other nuclear medicine)  Ambulance (to the nearest facility for appropriate care)  • Ground Ambulance • Air Ambulance • Air Ambulance • Testing and Diagnosis • Treatment  Biofeedback • Medical • Mental Health  Dematological Services  Services include education, self-management training, podiatric appliances, and equipment.  Drugs Administered in an Outpatient Setting (such as home, physician office and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental)  Deductible and Coinsurance Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance		Not Covered	Not Covered
Mambulance (to the nearest facility for appropriate care)   Ambulance (to the nearest facility for appropriate care)   Oround Ambulance   Deductible and Coinsurance   In-network level of benefits   In-network level	Advanced Diagnostic Imaging (CT, MRI, MRA,		
Ambulance (to the nearest facility for appropriate care)  • Ground Ambulance • Air Ambulance • Air Ambulance • Testing and Diagnosis • Treatment  Biofeedback • Medical • Mental Health  Dematological Services Services include education, self-management training, podiatric appliances, and equipment.  Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)  Deductible and Coinsurance		Deductible and Coinsurance	Deductible and Coinsurance
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<ul> <li>Air Ambulance</li> <li>Autism Spectrum Disorder         <ul> <li>Testing and Diagnosis</li> <li>Treatment</li> <li>Same as Mental Health</li> <li>Medical</li> <li>Mental Health</li> <li>Same as Mental Health</li> <li>Same as Mental Health</li> <li>Same as Mental Health</li> <li>Same as Mental Health</li> <li>Deductible and Coinsurance</li> <li>Deductible and Coinsurance</li></ul></li></ul>	care)		
Autism Spectrum Disorder      Testing and Diagnosis     Treatment     Same as Mental Health     Biofeedback     Medical     Mental Health     Same as Mental Health     Deductible and Coinsurance     Same as Mental Health     Same as Mental Health     Same as Mental Health     Same as Mental Health     Deductible and Coinsurance	<ul> <li>Ground Ambulance</li> </ul>	Deductible and Coinsurance	In-network level of benefits
<ul> <li>Testing and Diagnosis</li> <li>Treatment</li> <li>Biofeedback</li> <li>Medical</li> <li>Mental Health</li> <li>Mental Health</li> <li>Mental Health</li> <li>Mental Health</li> <li>Mental Health</li> <li>Deductible and Coinsurance</li> <li>Same as Mental Health</li> <li>Deductible and Coinsurance</li> <li>Same as Mental Health</li> <li>Same as Mental Health</li> <li>Deductible and Coinsurance</li> </ul>	<ul> <li>Air Ambulance</li> </ul>	Deductible and Coinsurance	In-network level of benefits
• Treatment  Biofeedback  • Medical  • Mental Health  Dematological Services  Diabetic Services  Services include education, self-management training, podiatric appliances, and equipment.  Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)  Deductible and Coinsurance	Autism Spectrum Disorder		
Biofeedback	<ul> <li>Testing and Diagnosis</li> </ul>	Same as Mental Health	Same as Mental Health
<ul> <li>Medical         <ul> <li>Mental Health</li> <li>Deductible and Coinsurance Same as Mental Health</li> <li>Deductible and Coinsurance</li> <li>Deductible and Coinsurance</li> </ul> </li> <li>Deductible and Coinsurance</li> <li>Deductible and Coinsurance</li> <li>Deductible and Coinsurance</li> </ul> <li>Deductible and Coinsurance</li>	<ul> <li>Treatment</li> </ul>	Same as Mental Health	Same as Mental Health
◆ Mental Health       Same as Mental Health       Same as Mental Health         Definatological Services       Deductible and Coinsurance       Deductible and Coinsurance         Diabetic Services       Deductible and Coinsurance       Deductible and Coinsurance         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       Deductible and Coinsurance       Deductible and Coinsurance	Biofeedback		
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Diabetic Services Services include education, self-management training, podiatric appliances, and equipment.  Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)  Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental	Mental Health	Same as Mental Health	Same as Mental Health
Diabetic Services Services include education, self-management training, podiatric appliances, and equipment.  Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)  Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental		Deductible and Coinsurance	Deductible and Coinsurance
Services include education, self-management training, podiatric appliances, and equipment.  Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)  Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental			
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Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)  Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental			
(such as home, physician office and other Outpatient settings)  Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental			
settings)  Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental		Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies         (including Prosthetics)       Deductible and Coinsurance         (rental or purchase, whichever is least costly, rental       Deductible and Coinsurance			
(including Prosthetics) (rental or purchase, whichever is least costly, rental  Deductible and Coinsurance  Deductible and Coinsurance			
(rental or purchase, whichever is least costly, rental			
		Deductible and Coinsurance	Deductible and Coinsurance

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Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Services		
Bone Anchored Hearing Aids	Deductible and Coinsurance	Deductible and Coinsurance
<ul> <li>Cochlear Implants</li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance
<ul> <li>Hearing Aids and related Services (up to</li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance
age 19, limited to \$3,000 every 48 months)	Deductible and Comsulance	Deductible and Comsulance
Home Health Care Services		
Home Health Aide (limited to 60 days per	Deductible and Coinsurance	Deductible and Coinsurance
Calendar Year)	Deductible and Cainaurana	Deductible and Coinsurance
Home Infusion Therapy  Page 1994 1994 1994 1994 1994 1994 1994 199	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance
<ul><li>Respiratory Care</li><li>Skilled Nursing Care (limited to 8 hours</li></ul>	Deductible and Comsulance	Deductible and Comsulance
per day)	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory	Boddonsio dila comediane	Doddensie und Cemedianie
Diagnostic	Deductible and Coinsurance	Deductible and Coinsurance
Infertility	Deadonale and Comediance	
Services to Diagnose	Deductible and Coinsurance	Deductible and Coinsurance
Treatment to Promote Fertility	Not Covered	Not Covered
Nicotine Addiction		
Medical Services and Therapy	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services
Nicotine Addiction Classes & Alternative	N . 0	N . 0
Therapy, such as Acupuncture	Not Covered	Not Covered
Obesity		
Non-Surgical Treatment	Not Covered	Not Covered
Surgical Treatment (limited to medically	Deductible and Coinsurance	Dadustible and Caingurance
necessary treatment of morbid obesity)	Deductible and Comsurance	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,	Deductible and Coinsurance	Deductible and Coinsurance
anesthesia, Inpatient Hospital visits and other non-		
surgical Services.		
Pregnancy, Maternity and Newborn Care		
Pregnancy and Maternity (payment for proposal and postpostal ears is included in	Deductible and Coinsurance	Deductible and Coinsurance
prenatal and postnatal care is included in the payment for the delivery)	Dennetible and Comsulation	Deductible and Collisurance
Newborn Care (newborns are covered at		
birth, subject to the plans enrollment	Deductible and Coinsurance	Deductible and Coinsurance
provisions)	Boddolibio dila comoditanto	Boddottblo dila comoditatio
<b>NOTE:</b> The plan pays 100% for the initial postpartum of	depression screening up to one year follow	ı ing a Pregnancy or childbirth
<b>NOTE:</b> Dependent child maternity is Not Covered, exce		
care-women/.	The state of the s	, ,a

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)	Deductible and Coinsurance	Deductible and Coinsurance
<ul> <li>Pulmonary Rehabilitation (limited to 36 sessions per Calendar Year)</li> </ul>	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
<ul> <li>Sterilization</li> <li>Elective sterilization female</li> <li>Elective sterilization male</li> </ul>	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)  NOTE: Treatment limits stated for physical therapy, occupa provided for Mental Health and/or Substance Use Disorder 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	Deductible and Coinsurance	Deductible and Coinsurance
<ul> <li>Vision Correction Surgery (keratomileusis surgery or LASIK surgery for myopia or aphakic hyperopia for employee only)</li> <li>Eye Exam</li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance
Diagnostic (to diagnose an Illness)     Preventive (routine exam including	See Physician Office Services	See Physician Office Services
refraction) limited to one exam per	Plan Pays 100%	Not Covered
Calendar Year		
Calendar Year Wigs	Not Covered	Not Covered

Prescription Drugs CVS Caremark	In-network Provider	Out-of-network Provider
Retail – per 30-day supply		
<ul> <li>Generic Drugs (Including non-preferred contraceptives)</li> </ul>	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		
<ul> <li>Generic Drugs (Including non-preferred contraceptives)</li> </ul>	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.

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