PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Group Name: City of Omaha
Police Bargaining
Active, Retired, COBRA

Effective Date: January 01, 2017

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. 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.		
BASIC BENEFITS		
Hospital Services • Inpatient Days *(Note: Basic Benefits do not apply to inpatient services for organ and tissue transplants, hospice care and skilled nursing facilities. Major Medical Benefits apply.)*	Plan Pays 100%	Covered under Major Medical Benefits
Outpatient and Physician Office Diagnostic Tests Radiology (x-ray) and pathology (lab) (limited to $100 per person per Calendar Year)	Plan Pays 100% (see Major Medical Benefits after Calendar Year maximum)	Covered under Major Medical Benefits
Physician Services (in the hospital)	Plan Pays 100%	Covered under see Major Medical Benefits
Pregnancy and Maternity, Complications of Pregnancy and Interruptions of Pregnancy Includes prenatal care, delivery, postnatal care and all pregnancy/maternity related Physician Services, Hospital charges and related Services	Plan Pays 100%	Covered under Major Medical Benefits
Newborn includes well newborn nursery and Physician fees, including hearing screening and circumcision	Plan Pays 100%	Covered under Major Medical Benefits
Surgical Services (Inpatient, Outpatient, Office) *(Note: Basic Benefits do not apply to organ and tissue transplants or vision correction surgery. Major Medical Benefits apply.)*	Plan Pays 100%	Covered under Major Medical Benefits

Payment for Services	In-network Provider	Out-of-network Provider
MAJOR MEDICAL BENEFITS		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
• Individual	$300	$300
• Employee + 1	$300	$300
• Family	$300	$300
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
• Covered Person Pays	20%	20%
Medical Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)		
• Individual	$700	$700
• Employee + 1 (Embedded*)	$1,100	$1,100
• Family (Embedded*)	$1,100	$1,100
Once the annual Medical Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
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.		
*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:

- Prescription Drugs

The Copay amount varies by the type of Covered Service. Refer to the appropriate category for benefit information.

Medical Out-of-pocket Limit includes:

- Medical Deductible
- Medical Coinsurance

Prescription Drug Out-of-pocket Limit includes:

- Prescription Drug Deductible
- Prescription Drug Coinsurance
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office Primary Care Physician Office Visit, Specialist Physician Office Visit, and other Covered Services and supplies provided in the Physician's office (with or without an office visit billed)	Deductible and Coinsurance	Deductible and Coinsurance
• Surgical Services in Office	See Basic Benefits	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.		
Telehealth Services (by a designated provider)	Deductible and Coinsurance	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 Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services **NOTE:** Waive Deductible and Coinsurance when due to an emergency or accident.	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as 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	See Basic Benefits	Deductible and Coinsurance

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%	<u>EMPLOYEE ONLY</u> Plan Pays 100% of first $175, then subject to Deductible and Coinsurance <u>DEPENDENTS</u> Not Covered
• Routine Mammograms	Plan Pays 100%	Deductible and Coinsurance
• Routine Colonoscopies	Plan Pays 100%	Deductible and Coinsurance

Mental Illness and/or Substance Dependence and Abuse Covered Services	In-network Provider	Out-of-network Provider
Inpatient Services	See Basic Benefits	Deductible and Coinsurance
Outpatient Services • Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care 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

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 Disorders (limited to Covered Persons up to age 21)	Deductible and Coinsurance	Deductible and Coinsurance
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	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
Eye Glasses 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 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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Devices • Cochlear implants • Bone anchored hearing aids • Hearing aids	 Deductible and Coinsurance Deductible and Coinsurance Not Covered	 Deductible and Coinsurance Deductible and Coinsurance Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services (limited to 180 days while covered under the Plan)	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 Dependence and Abuse Not Covered	 Same as Substance Dependence and Abuse Not Covered
Obesity • Non-surgical treatment • Surgical Treatment	 Not Covered See Basic Benefits	 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).	Same as any other illness	Same as any other illness
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	See Appropriate Category for Service Provided	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)	See Basic Benefits	Deductible and Coinsurance
• Newborn care	See Basic Benefits	Deductible and Coinsurance
NOTE: Dependent child maternity, including complications, is Not Covered. **NOTE**: Newborns are covered at birth, subject to the plan's enrollment provisions.		
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	See Basic Benefits	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (limited to 36 sessions per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care	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% Plan Pays 100%	 Deductible and Coinsurance Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder (limited to $2500 while Covered under the Plan)	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
Vision Correction Surgery (employee only)	Deductible and Coinsurance	Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction limited to one per Calendar Year)	Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Plan Pays $40 then Deductible and Coinsurance
Vision Hardware • Children (newborn up to age 19) • Adult (age 19 and over)	Plan Pays $150 then Deductible and Coinsurance Plan Pays up to $150 per Covered Person	Plan Pays $150 then Deductible and Coinsurance Plan Pays up to $150 per Covered Person
Wigs	Not Covered	Not Covered
All Other Covered Services	See Appropriate Category for Service Provided	See Appropriate Category for Service Provided

Prescription Drugs	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 are applicable) • Individual/Family	$60	
Prescription Drug Out-of-pocket Limit • Individual/Family (includes Prescription Drug Deductible)	$560	
Retail – per 30-day supply		
• Generic drugs (including non-formulary contraceptives)	20%	Deductible and 50% Penalty
• Formulary Brand Name Drugs	20%	Deductible and 50% Penalty
• Non-formulary Brand Name Drugs	20%	Deductible and 50% Penalty
NOTE: After the Prescription Drug Out-of-pocket limit is reached, the retail Copayment is $3		
Mail order – up to 90-day supply		
• Generic drugs (including non-formulary contraceptives)	$9 Copay	Not Covered
• Formulary Brand Name Drugs	$9 Copay	Not Covered
• Non-formulary Brand Name Drugs	$9 Copay	Not Covered
NOTE: After the Prescription Drug Out-of-pocket limit is reached, the mail order Copayment continues to be $9.***		
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)		
• Generic drugs	$3	Not Covered
• Formulary Brand Name Drugs	$3	Not Covered
• Non-formulary Brand Name Drugs	$3	Not Covered
NOTE: After the Prescription Drug Out-of-pocket limit is reached, the specialty drug Copayment continues to be $3 per 30-day supply***		
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	50% Penalty
Obesity FDA approved prescription drugs	Not Covered	Not Covered
Contraceptives which require a Physician's written prescription are **included**. There are certain contraceptive prescriptions that will be covered at no cost share to the Covered Person. Please refer to the website on your ID card.		

***After the Prescription Drug Copays and/or Coinsurance have reached an out-of-pocket maximum of $5,340 (individual) or $11,540 (family) (not including the Prescription Drug Out-of-pocket limit), the Plan Pays 100% of covered prescription drug charges for the remainder of the calendar year.

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.