2026 CITY OF HASTINGS INSURANCE INFORMATION
Fire Union Employees
Effective 1-1-26

HEALTH PLAN - Blue Cross/Blue Shield of NE -- PPO Plan (Embedded Deductible)								
	MONTHLY COSTS				DEDUCTIBLES		MAX OUT OF POCKET (includes deductibles)	
	Employee	Employer	Total MO Premium	% of Premium	In Network	Out-of-Network	In Network	Out-of-Network
Single	$92.89	$1,098.02	$1,190.91	7.8 / 92.2	$1,250	$2,500	$3,000	$6,000
Family	$375.28	$2,364.02	$2,739.30	13.7 / 86.3	$2,500	$5,000	$6,000	$12,000
HEALTH PLAN - Blue Cross/Blue Shield of NE -- Qualified High Deductible Health Plan (Aggregate Deductible)								
Single	$175	$992	$1,167	15 / 85	$1,800	$3,600	$2,500	$5,000
EE + Sp	$348	$1,971	$2,319	15 / 85	$3,600	$7,200	$5,000	$10,000
EE+ Ch	$334	$1,890	$2,224	15 / 85	$3,600	$6,400	$5,000	$10,000
Family	$405	$2,292	$2,697	15 / 85	$3,600	$6,400	$5,000	$10,000

OFFICE CO-PAYS			CO-INSURANCE	
Physician	In Network	Out of Network	In Network	Out of Network
PPO - Primary Care Physician	$0 Telehealth $35 Office	50% after deductible	80 / 20	50 / 50
PPO - Specialty Physician	$0 Telehealth $75 Office	50% after deductible		
QHDHP - Primary Care Physician	20% after deductible	50% after deductible	80 / 20	50 / 50
QHDHP - Specialty Physician	20% after deductible	50% after deductible		

RETAIL PRESCRIPTIONS Per 30-day supply			
Generic* - PPO	Preferred Brand Name* - PPO	Non-Preferred Brand Name* - PPO	Specialty -- PPO
$15 copay plus 10% of remaining balance	$50 copay plus 20% of remaining balance	$75 copay plus 30% of remaining balance	30% up to $500 max per prescription through designated pharmacy only
Generic* -QHDHP	Preferred Brand Name* - QHDHP	Non-Preferred Brand Name* - QHDHP	Specialty - QHDHP
20% after deductible	20% after deductible	20% after deductible	20% after deductible

MAIL ORDER - Per 90-day supply			
Generic** - PPO	Preferred Brand Name** - PPO	Non-Preferred Brand Name** - PPO	*Retail Prescriptions - 25% added penalty if using out-of-network provider pharmacy.
$45 copay plus 10% of remaining balance	$150 copay plus 20% of remaining balance	$225 copay plus 30% of remaining balance	
Generic* -QHDHP	Preferred Brand Name* - QHDHP	Non-Preferred Brand Name* - QHDHP	** Mail Order Prescriptions – not covered if using out-of-network provider pharmacy.
20% after deductible	20% after deductible	20% after deductible	

DENTAL PLAN - Blue Cross/Blue Shield of NE			
Election	DENTAL - Blue Cross/Blue Shield		
	Employee	Employer	Total MO Premium
Single	$12.55	$20.00	$32.55
Family*	$93.04	$20.00	$113.04

***Includes Orthodontia coverage for children under age 19.**

VISION PLAN - Ameritas (VSP)		
Election	Employee	Employer
Single	$12.12	$0.00
Emp + Spouse	$25.64	$0.00
Emp + Children	$23.06	$0.00
Family	$33.98	$0.00

LONG-TERM DISABILITY - Mutual of Omaha
Up to 60% of before-tax monthly earnings Benefits begin after 90 calendar days after onset of disabling injury or illness
VOLUNTARY SHORT-TERM DISABILITY - Mutual of Omaha
Up to 60% of before-tax monthly earnings Benefits begin after 7 calendar days after onset of disabling injury or illness
LIFE INSURANCE – Mutual of Omaha
Annual Salary rounded up to nearest $1,000; max. of $50,000