PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

ATU/DSS/M/W/LCEA/E/X/Mayor

Group Name: City of Lincoln

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. Cost-sharing and reimbursement amounts for categories showing "Same as any other Illness" may vary based on where Services are rendered.		
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 • Family (Embedded*)	 $400 $800	 $800 $1,600
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays • Plan Pays	 20% 80%	 30% 70%
Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments) • Individual • Family (Embedded*)	 $2,100 $4,200	 $3,100 $6,200
NOTE: Amounts paid for Prescription Drugs will be applied to your Deductible and Out-of-pocket Limits.		
In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not 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: • Physician Office • Emergency Room Services • Manipulations and Adjustments • Telehealth/Virtual Care • Inpatient Hospital or Facility Services • Behavioral health in the home, Partial Hospitalization, Intensive Outpatient • Urgent Care Facility • Physical, Occupational, Speech Therapy The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.		
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	$25 Copay	Deductible and Coinsurance
Specialist Physician Office Visit	$25 Copay	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.		
Physician Office Services	Applicable Office Visit Copay	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, infusions, chemotherapy and radiation therapy and surgery and anesthesia. 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**, **Advanced Diagnostic Imaging** (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine), **Durable Medical Equipment**, **Pregnancy, Maternity** and **Newborn Care**, **Sleep Studies**, and **Therapy** and **Manipulations**. *(Refer to the appropriate categories below and your benefit book for additional information.)*		
Telehealth/Virtual Care Services • Medical • Mental Health	$25 Copay See Mental Health and/or Substance Use Disorder Services	Deductible and Coinsurance See Mental Health and/or Substance Use Disorder Services
Convenient Care/Retail Clinics/Quick Care	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services (a single Copay applies to each urgent care visit)	$40 Copay	Deductible and Coinsurance
Emergency Room Services • Facility • Professional Services (Copay waived when admitted to the Hospital within 24 hours for the same diagnosis)	$150 Copay then 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.	$100 Copay then Deductible and Coinsurance	$100 Copay then Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services • Inpatient • Outpatient	$100 Copay then Deductible and Coinsurance Deductible and Coinsurance	$100 Copay then Deductible and Coinsurance Deductible and Coinsurance

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services		
• Affordable Care Act (ACA) required Preventive Services (may be subject to limits that include but are not limited to age, gender, and frequency)	Plan Pays 100%	Deductible and Coinsurance
• ACA-required covered Preventive Services (outside of limits)	Same as any other Illness	Deductible and Coinsurance
• Other covered Preventive Services not required by ACA		
- Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; metabolic panel; prostate cancer screening (PSA) and hearing exams	Plan Pays 100%	Deductible and Coinsurance
- All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services	Plan Pays 100%	Deductible and Coinsurance
For additional information visit NebraskaBlue.com/PreventiveCare		
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Coinsurance
• Age 7 and older	Plan Pays 100%	Deductible and Coinsurance
• Related to an Illness	Same as any other Illness	Same as any other Illness
Colorectal Cancer Screenings (starting at age 45)		
• Colonoscopy Screening		
- Diagnostic or Preventive Screening (one every five years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Same as any other Illness	Deductible and Coinsurance
• Sigmoidoscopy/Proctoscopy Screening and CT of the Colon		
- Preventive Screening (one every five years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Same as any other Illness	Deductible and Coinsurance
• FIT DNA		
- Preventive Screening (one every three years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Same as any other Illness	Deductible and Coinsurance
• Fecal Occult Blood Test		
- Preventive Screening (one per year)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Same as any other Illness	Deductible and Coinsurance
• Barium Enema, and other tests as determined under ACA Preventive Services		
- Preventive Screenings	Plan Pays 100%	Deductible and Coinsurance
- Diagnostic Screenings	Same as any other Illness	Deductible and Coinsurance
NOTE: Related Services will pay in the same manner as the Colorectal Cancer Screening when performed on the same date of service. Screening limits accumulate based on a Calendar Year.		

Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Office Visit	$25 Copay	Deductible and Coinsurance
Benefits for **office visit** include the **office visit**, medication checks, psychological therapy and/or Substance Use Disorder counseling.		
Office Services	Applicable Office Visit Copay	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**.		
All Other Outpatient Items and Services (excluding laboratory tests and x-rays. Refer to the appropriate category for benefit information)	$25 Copay	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.		
Behavior Health in the Home, Partial Hospitalization and Intensive Outpatient	$25 Copay	Deductible and Coinsurance
Telehealth/Virtual Care Services	$25 Copay	Deductible and Coinsurance
Emergency Room Services • Facility • Professional Services (Copay waived when admitted to the Hospital within 24 hours for the same diagnosis)	$150 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Inpatient Services	$100 Copay then Deductible and Coinsurance	$100 Copay then 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 (when in lieu of anesthesia used for covered surgery, all other services are non-covered)	Deductible and Coinsurance	Deductible and Coinsurance
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine) • Office • Outpatient • Inpatient	Plan Pays 100% Plan Pays 100% Plan Pays 100%	Deductible and Coinsurance 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	Same as any other Illness	Same as any other Illness
Diabetic Services Services include education, self-management training, podiatric appliances, and equipment.	Same as any other Illness	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)	Same as any other Illness	Same as any other Illness
NOTE: Benefits for specific prescription drugs are covered under the prescription drug plan and not payable under medical, other than in an emergency room. A list of these specific drugs is available at NebraskaBlue.com/Pharmacy or by contacting the Member Services department.		
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
Foot Orthotics – When ordered by a Physician	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 (limited to $3,000 per ear 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 and Skilled Nursing Care (60 visits per Calendar Year*) • Home Infusion Therapy • Respiratory Care	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
NOTE: *Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours per day.		
Hospice Services • Outpatient (limited to 8 hours per day) • Inpatient	 Deductible and Coinsurance $100 Copay then Deductible and Coinsurance	 Deductible and Coinsurance $100 Copay then Deductible and Coinsurance
Infertility • Services to Diagnose • Treatment to Promote Fertility (limited to a total of $15,000 maximum while covered under the plan)	 Same as any other Illness Same as any other Illness	 Deductible and Coinsurance Deductible and Coinsurance
Laboratory • Diagnostic - Independent Laboratory - Office - Outpatient - Inpatient • Preventive	 Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Same as Preventive Services In-network level of benefits	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
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	 Not Covered Not Covered	 Not Covered Not Covered
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. 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	Deductible and Coinsurance
Organ and Tissue Transplantation • Transplant Surgical Services – Designated transplant at a Blue Distinction Center (limited to the day before, surgery, and confinement) • Transplant Surgical Services (not part of the Blue Distinction transplant program) • Preoperative and postoperative Services (not included in the above provisions)	 Blue Distinction Center: Deductible and Coinsurance (All non-Blue Distinction Centers: Out-of-Network Deductible and Coinsurance) Same as any other illness Same as any other illness	 Deductible and Coinsurance Same as any other illness Same as any other illness
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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Pregnancy, Maternity and Newborn Care		
• Pregnancy and Maternity (payment for prenatal and postnatal care is included in the payment for the delivery)	Deductible and Coinsurance	Deductible and Coinsurance
• Newborn Care (newborns are covered at birth, subject to the plans enrollment provisions)	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.		
Radiation Therapy and Chemotherapy		
• Office Visit	See Physician Office Services	Deductible and Coinsurance
• Outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and Other Diagnostic Tests		
• Office Visit	Plan Pays 100%	Deductible and Coinsurance
• Outpatient	Plan Pays 100%	Deductible and Coinsurance
• Inpatient	Plan Pays 100%	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	$100 Copay then Deductible and Coinsurance	$100 Copay then Deductible and Coinsurance
Rehabilitation Services		
• Cardiac Rehabilitation	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Sexual Dysfunction	Same as any other illness	Deductible and Coinsurance
Skilled Nursing Facility (limited to 60 days per Calendar Year)	$100 Copay then Deductible and Coinsurance	$100 Copay then Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Same as any other Illness	Deductible and Coinsurance
Therapy & Manipulations		
• Physical, Occupational or Speech Therapy Services (Rehabilitative Services combined limit of 60 sessions per Calendar No limit for Habilitative Services).	$25 Copay	Deductible and Coinsurance
• Chiropractic or Osteopathic Manipulative Treatments or Adjustments (combined limit of 30 sessions per Calendar Year)	$25 Copay	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)	Deductible and Coinsurance	Deductible and Coinsurance
• Eye Exam		
- Diagnostic (to diagnose an Illness)	See Physician Office Services	See Physician Office Services
- Preventive (routine exam including refraction) limited to one exam every two Calendar Years	Plan Pays 100%	Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance