PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Group Name: Lauritzen Corporation

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	$2,500	$5,000
• Family (Embedded*)	$5,000	$10,000
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
• Covered Person Pays	20%	40%
• Plan Pays	80%	60%
Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments)		
• Individual	$5,000	$10,000
• Family (Embedded*)	$10,000	$20,000
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: • Physician Office • Telehealth/Virtual Care • Urgent Care Facility • Emergency Room Services • Physical, Occupational, Speech Therapy • Manipulations and Adjustments • Prescription Drugs 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	$75 Copay	Deductible and Coinsurance
Allergy Testing and Treatment	$75 Copay	Deductible and Coinsurance
Allergy Injections and Serum	Coinsurance Only	Deductible and Coinsurance
Surgery in the Office	Deductible and Coinsurance	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, 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; Allergy injections and serums, **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 • Medical - Telescope Telehealth - All Other Providers • Mental Health - Telescope Telehealth - All Other Providers	 $15 Copay Same As In Person Visit $15 Copay $25 Copay	 Not Covered Deductible and Coinsurance Not Covered Deductible and Coinsurance
You can access Telescope Telehealth through your account at myNebraskaBlue.com		
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)	$75 Copay	Deductible and Coinsurance
Emergency Room Services • Facility • Professional Services (Copay waived when admitted to the Hospital within 24 hours for the same diagnosis)	$350 Copay Plan Pays 100%	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.	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)	Plan Pays 100%	Deductible and Coinsurance
• Other covered Preventive Services not required by ACA, such as:		
- Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; comprehensive 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	Plan Pays 100%	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	Plan Pays 100%	Deductible and Coinsurance
• FIT DNA		
- Preventive Screening (one every three years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Plan Pays 100%	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	Plan Pays 100%	Deductible and Coinsurance
• Barium Enema, and other tests as determined under ACA Preventive Services		
- Preventive Screenings	Plan Pays 100%	Deductible and Coinsurance
- Diagnostic Screenings	Plan Pays 100%	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.		
Breast Cancer Screenings		
• Mammogram	Plan Pays 100%	Deductible and Coinsurance
Per National Comprehensive Cancer Network (NCCN) and provider recommendation, Increased risk of breast cancer due to family or personal history of breast cancer or prior atypical breast biopsy, positive genetic testing, or heterogeneous or dense breast tissue based on a breast imaging.		
• Mammogram	Plan Pays 100%	Deductible and Coinsurance
• Digital Tomosynthesis	Plan Pays 100%	Deductible and Coinsurance
• Whole Breast Ultrasound (1 per Calendar Year)	Plan Pays 100%	Deductible and Coinsurance
Per NCCN and provider recommendation, Increased risk of breast cancer due to family or personal history of breast cancer or prior atypical breast biopsy, positive genetic testing, or history of chest radiation.		
• Diagnostic MRI (1 per Calendar Year)	Plan Pays 100%	Deductible and Coinsurance
Per NCCN guidelines, Increased risk of breast cancer and heterogeneous or dense breast tissue.		
• Diagnostic MRI (1 per Calendar Year)	Same as any other illness	Deductible and Coinsurance

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, with or without an **office visit**; X-rays, laboratory tests, supplies and/or drugs administered during the **office visit**.		
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, or any other covered Mental Health and/or Substance Use Disorder Services.		
Telehealth/Virtual Care Services • Telescope Telehealth • All Other Providers	 $15 Copay $25 Copay	 Not Covered Deductible and Coinsurance
You can access Telescope Telehealth through your account at myNebraskaBlue.com		
Emergency Room Services • Facility • Professional Services (Copay waived when admitted to the Hospital within 24 hours for the same diagnosis)	 $350 Copay Plan Pays 100%	 In-network level of benefits In-network level of benefits
Inpatient Services	Deductible and Coinsurance	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	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 Disorder • Testing and Diagnosis • Treatment	 Coinsurance Only Coinsurance Only	 Deductible and Coinsurance Deductible and Coinsurance
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. • Diabetic Supplies	 Same as any other Illness Plan Pays 100%	 Deductible and Coinsurance 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
Hearing Services • Bone Anchored Hearing Aids • Cochlear Implants • Hearing Aids and related Services (Plan Pays up to $3,000 every 3 Calendar Years after Deductible has been met and any applicable Coinsurance) • Hearing Exam (limited to two exams per Calendar Year)	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Plan Pays 100%	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services		
• Home Health Aide (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
• Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
• Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
• Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic	Plan Pays 100%	In-network level of benefits
• Preventive	Plan Pays 100%	In-network level of benefits
Infertility		
• Services to Diagnose	Same as any other Illness	Deductible and Coinsurance
• Treatment to Promote Fertility (Limited to $20,000 Medical lifetime maximum, while covered under the Plan)	Same as any other Illness	Deductible and Coinsurance
Nicotine Addiction		
• Medical Services and Therapy	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services
• Nicotine Addiction Classes & Alternative Therapy, such as Acupuncture	Not Covered	Not Covered
Obesity		
• Non-Surgical Treatment	Not Covered	Not Covered
• Surgical Treatment	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)	Blue Distinction Center: Deductible and Coinsurance (All non-Blue Distinction Centers: Out of Network Deductible and Coinsurance)	Deductible and Coinsurance
• Transplant Surgical Services (not part of the Blue Distinction transplant program)	Same as any other illness	Same as any other illness
• Preoperative and postoperative Services (not included in the above provisions)	Same as any other illness	Same as any other illness
NOTE: Transportation and lodging required for travel to a Blue Distinction Center for the covered surgical procedure for the Covered Person and one companion, or two parents/guardians if the patient is a minor. No benefit is available for travel less than 100 miles. Lodging is reimbursed at a rate of $50 per night per person, up to a maximum of $100 per night.		
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) • Newborn Care (newborns are covered at birth, subject to the plans enrollment provisions)	Deductible and Coinsurance Deductible and Coinsurance	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	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 • Pulmonary Rehabilitation	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Sexual Dysfunction	Deductible and Coinsurance	Deductible and Coinsurance
Skilled Nursing Facility (limited to 90 days per Calendar Year)	Deductible and Coinsurance	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, Chiropractic or Osteopathic physiotherapy (combined limit of 90 sessions per Calendar Year for rehabilitative Services. No session limit for habilitative Services.) • Chiropractic Services including but not limited to office visits, radiology, pathology, physiotherapy, manipulations/adjustments (combined limit to 60 sessions per Calendar Year)	 $25 Copay $25 Copay	 Deductible and Coinsurance 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 or Substance Use Disorders. Evaluations are covered and do not apply to the combined calendar year limit.		
Vision Services • Eyeglasses or Contact Lenses including refraction (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) • Eye Exam - Diagnostic (to diagnose an Illness) - Preventive (routine exam including refraction) limited to one exam per Calendar Year	 Deductible and Coinsurance See Physician Office Services Plan Pays 100%	 Deductible and Coinsurance See Physician Office Services Deductible and Coinsurance
Voluntary Sterilization • Tubal ligation • Vasectomy	 Plan Pays 100% Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Wigs (One per Calendar Year if hair loss is due to a medical condition)	Deductible and Coinsurance	Deductible and Coinsurance
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs	In-network Provider	Out-of-network Provider
Retail – per 30-day supply		
• Preferred Generic Drugs	$10 Copay	$10 Copay + 25% Penalty
• Non-Preferred Generic Drugs	$10 Copay	$10 Copay + 25% Penalty
• Preferred Brand Name Drugs	20% Coinsurance, up to $100 Maximum	20% Coinsurance, up to $100 Maximum + 25% Penalty
• Non-Preferred Brand Name Drugs	20% Coinsurance, up to $175 Maximum	20% Coinsurance, up to $175 Maximum + 25% Penalty
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy subject to 2 Copays.		
Home Delivery – per 90-day supply		
• Preferred Generic Drugs	$20 Copay	Not Covered
• Non-Preferred Generic Drugs	$20 Copay	Not Covered
• Preferred Brand Name Drugs	20% Coinsurance, up to $200 Maximum	Not Covered
• Non-Preferred Brand Name Drugs	20% Coinsurance, up to $350 Maximum	Not Covered
Specialty Drugs (Specialty Drugs must be purchased through a designated Specialty Pharmacy)		
• Preferred Specialty Drugs	20% Coinsurance, up to $250 Maximum	Not Covered
• Non-Preferred Specialty Drugs	20% Coinsurance, up to $250 Maximum	Not Covered
Infertility FDA Approved prescription drugs to promote fertility (Limited to $15,000 Prescription Drug lifetime maximum while covered under the plan)	Same as any other prescription drug	Same as any other prescription drug
Contraceptive Drugs		
• Contraceptive Drugs and Methods in accordance with Federal Guidelines	Plan Pays 100%	Plan Pays 100% + 25% Penalty
• All other Contraceptive Drugs and Methods	Same as any other Generic or Brand Name Drugs	Same as Retail + 25% Penalty
For additional information see Women's Services listed on NebraskaBlue.com/PreventiveCare		
Diabetic Supplies	Plan Pays 100%	Plan Pays 100% + 25% Penalty
Diabetic Insulin		
• Preferred Generic Drugs	$10 Copay	$10 Copay + 25% Penalty
• Non-Preferred Generic Drugs	$10 Copay	$10 Copay + 25% Penalty
• Preferred Brand Name Drugs	20% Coinsurance, up to $100 Maximum	20% Coinsurance, up to $100 Maximum + 25% Penalty
• Non-Preferred Brand Name Drugs	20% Coinsurance, up to $175 Maximum	20% Coinsurance, up to $175 Maximum + 25% Penalty
This plan utilizes the Open Network and NetResults Biosimilar Plus Prescription Drug List (PDL25). You can find this PDL and network listing on NebraskaBlue.com/Pharmacy or you may contact Member Services at the phone number on the back of your I.D. card.		

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.