

QUICK REFERENCE GUIDE

2026-27 Health Benefits

Medical & Dental Premiums (Temp)



Monthly Medical Plan Premiums

The monthly premiums for your medical, dental, and vision plans for July 1, 2026, through June 30, 2027, are shown below. The state contributes 79% of the total cost of your health care benefits for full-time public servants. Premiums are deducted from your paycheck pre-tax, meaning you do not pay taxes on them as they are deducted from your pay before taxes are withheld.

It is your responsibility to review your pay stub to ensure that the proper deductions are taken. You are responsible for the cost of the proper public servant share of your elected benefits. A payroll error does not absolve you of responsibility for payment of the proper share of the cost.

Full-Time Public Servant Rates

Note: For Public Servants paid bi-weekly, your deduction will be half the total shown here. Deductions are taken 24 times per year.

		Regular Health Plan NEtwork BLUE (Broad Network)	Regular Health Plan Premier Select BlueChoice (Narrow Network)	Regular Health Plan Blueprint Health (Narrow Network)	Consumer Focused Health Plan NetworkBLUE (Broad Network)	Consumer Focused Health Plan Premier Select BlueChoice (Narrow Network)	Consumer Focused Health Plan Blueprint Health (Narrow Network)
Employee Only (Single Coverage)	Your Cost:	\$225.98	\$192.30	\$192.30	\$133.36	\$113.48	\$113.48
	State Cost:	\$850.18	\$723.42	\$723.42	\$501.70	\$426.96	\$426.96
	Total:	\$1,076.16	\$915.72	\$915.72	\$635.06	\$540.44	\$540.44
Employee + Spouse (Two-Party Coverage)	Your Cost:	\$598.86	\$509.60	\$509.60	\$353.40	\$300.74	\$300.74
	State Cost:	\$2,252.90	\$1,917.06	\$1,917.06	\$1,329.50	\$1,131.42	\$1,131.42
	Total:	\$2,851.76	\$2,426.66	\$2,426.66	\$1,682.90	\$1,432.16	\$1,432.16
Employee + Dependent Children (Four-Party Coverage)	Your Cost:	\$463.28	\$394.22	\$394.22	\$273.40	\$232.66	\$232.66
	State Cost:	\$1,742.82	\$1,483.02	\$1,483.02	\$1,028.50	\$875.26	\$875.26
	Total:	\$2,206.10	\$1,877.24	\$1,877.24	\$1,301.90	\$1,107.92	\$1,107.92
Employee + Spouse + Dependent Children (Family Coverage)	Your Cost:	\$802.26	\$682.66	\$682.66	\$473.44	\$402.90	\$402.90
	State Cost:	\$3,018.02	\$2,568.12	\$2,568.12	\$1,781.02	\$1,515.66	\$1,515.66
	Total:	\$3,820.28	\$3,250.78	\$3,250.78	\$2,254.46	\$1,918.56	\$1,918.56



Monthly Dental Plan Premiums

	Basic Option	Premium Option
Employee Only (Single Coverage)	\$27.50	\$32.20
Employee + Spouse (Two-Party Coverage)	\$55.10	\$64.44
Employee + Dependent Children (Four-Party Coverage)	\$79.46	\$92.90
Employee + Spouse + Dependent Children (Family Coverage)	\$86.56	\$100.86

IMPORTANT INFORMATION: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official documents. If there are any inconsistencies between this summary and the official plan documents, the plan document will prevail. Refer to the summary plan documents found on Employee Wellness & Benefits website at das.nebraska.gov/personnel/wellness/index.html for exact benefits, exclusions and limitations.

	Regular Health Plan		Consumer Focused Health Plan (HSA Eligible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible (must be satisfied before coinsurance is paid)	\$1,400 individual \$2,600 family	\$2,800 individual \$5,200 family	\$3,400 individual \$5,200 family	\$5,200 individual \$10,400 family
Annual Medical Out-of-Pocket Maximum (deductible, coinsurance, & medical co-pays)	\$4,000 individual \$8,000 family	\$8,000 individual \$16,000 family	\$4,300 individual \$8,200 family	\$8,200 individual \$16,400 family
Annual Pharmacy Out-of-Pocket Maximum	\$2,250 individual \$4,500 family		Included in the medical out-of-pocket maximum	
PHYSICIAN OFFICE VISITS				
Primary Care Physician Office visit	\$45 copay	40% after deductible	20% after deductible	40% after deductible
Specialty Office visit	\$55 copay	40% after deductible		
Telehealth/Virtual Care Visits - Telescope (preferred provider) - All other providers	Plan pays 100% Same as in-person visit	Not covered 40% after deductible		Not covered 40% after deductible
Allergy testing / serum	20% after deductible			
Allergy shots				
Lab and Pathology Services				
Radiology and Chemotherapy/Radiation Therapy				
Routine Vision Exam plus Refraction	Not covered		Not covered	
PREVENTIVE EXAMS				
Services include flu shots, immunizations, preventive exams, well-baby exams, routine pre-natal visits, mammogram, colonoscopies, and diabetes vision screening. See Summary Plan Document on Employee Wellness & Benefits website for a comprehensive list of your preventive care services.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines.
EMERGENCY CARE				
Ambulance	20% after deductible		20% after deductible	
Urgent care center	\$75 copay	40% after deductible	20% after deductible	40% after deductible
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient and outpatient hospital services Approved skilled nursing facility Home health care, Hospice care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
BEHAVIORAL HEALTH SERVICES				
Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient	\$45 copay			
OTHER SERVICES				
Chiropractic Office visit (Limit 20 sessions per plan year) Therapy - Occupational, Physical, Speech (Combined limit of 60 sessions per plan year) Hearing aids & exam (Limit \$3,500 every 3 years)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
MATERNITY SERVICES				
Outpatient maternity services (medically necessary)	Plan pays 100%	40% after deductible	20% after deductible	40% after deductible
Inpatient maternity related hospital charges (medically necessary)	Plan pays 100%	40% after deductible	20% after deductible	40% after deductible
Inpatient well baby nursery (eligible charges)	Plan pays 100%	30% coinsurance only	20% - coinsurance only	40% coinsurance only

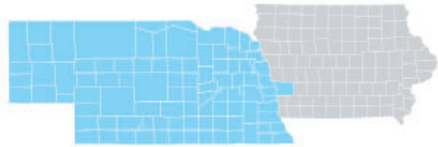
NEtwork BLUE

NEtwork BLUE is our statewide network, made up of 99% of Nebraska's doctors and 98% non-governmental acute care hospitals.*

NEtwork BLUE provides access to:

- Hospitals and clinics across Nebraska
- Primary and specialty care providers
- Heart, cancer and trauma centers
- Children's care
- Behavioral health network

* Source: BCBSNE statistics. Jan. 15, 2026



Premier Select BlueChoice

Premier Select BlueChoice is a regional network available in Omaha, Lincoln, Council Bluffs and surrounding communities in ZIP codes starting with 515 (Pottawattamie county only), 680, 681, 683, 684 and 685. All other Nebraska and Iowa providers are out of network.

Some of the key hospitals and health care providers include:

- Boys Town National Research Hospital
- Bryan Health
- Children's Nebraska
- Methodist Hospital System
- Nebraska Medicine

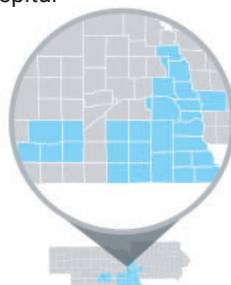


Blueprint Health

Blueprint Health is a regional network available in Omaha, Lincoln, Council Bluffs and surrounding communities in ZIP codes starting with 515 (Pottawattamie county only) 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties. All other Nebraska and Iowa providers are out of network.

Some of the key hospitals and health care providers include:

- Boys Town National Research Hospital
- CHI Health System
- Children's Nebraska
- Nebraska Spine Hospital LLC



Your Pharmacy Benefits

All Other Plans

BCBSNE PREVENTIVE DRUG LIST (FORMULARY)

For list, go to Wellness & Benefits Resources page at das.nebraska.gov/personnel/wellness/index.html.

RETAIL - 30 DAY SUPPLY

Tier 1	No copay
Tier 2	No copay
Tier 3	\$25 copay
Tier 4	\$50 copay

MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY

Tier 1	
Tier 2	2 Times the 30-day supply
Tier 3	
Tier 4	

Consumer Focused Health Plan

1. If your medication is on the BCBSNE Preventive Drug List, you pay the copay. Your copay will apply towards your annual out-of-pocket maximum. After your limit is met, the plan pays 100% of your costs. For more details, go to das.nebraska.gov/personnel/wellness/index.html.
2. For all other covered prescriptions, the full cost of the prescription is applied towards your deductible. Once you meet your deductible, then you pay 20% coinsurance until your annual out-of-pocket limit is met. Then all costs are paid 100% by the plan.

Continued...

Your Pharmacy Benefits

	Regular Health Plan	Consumer Focused Health Plan (HSA Eligible)
RETAIL - 30 DAY SUPPLY		
Tier 1	\$5 copay	20% after deductible
Tier 2	\$5 copay	20% after deductible
Tier 3	\$40 copay	20% after deductible
Tier 4	\$60 copay	20% after deductible
MAIL ORDER (OR RETAIL) - 90 DAY SUPPLY		
Tier 1	\$10 copay	20% after deductible
Tier 2	\$10 copay	20% after deductible
Tier 3	\$80 copay	20% after deductible
Tier 4	\$120 copay	20% after deductible
Pharmacy Out-of-Pocket Maximum	\$2,250 - individual \$4,500 - family	20% after deductible
SPECIALTY DRUG CATEGORY		
Preferred Specialty Drugs	\$100 copay	20% after deductible
Non-Preferred Specialty Drugs	\$100 copay	20% after deductible

Pay the Difference

If a **lower cost** generic equivalent is available and you choose brand name drug, you will pay the difference in cost between the generic cost and brand name cost, in addition to the appropriate copay. This penalty does not apply if physician does not allow substitution.

Pharmacy Out-Of-Pocket Maximums

The pharmacy out-of-pocket maximum limits are in addition to the medical out-of-pocket maximums on page 24. Once the out-of-pocket maximum has been met for pharmacy co-pays, all prescriptions covered under the plan will be paid 100% by the plan.

Part-Time Public Servant Rates

		Regular Health Plan NEtwork BLUE (Broad Network)	Regular Health Plan Premier Select BlueChoice (Narrow Network)	Regular Health Plan Blueprint Health (Narrow Network)	Consumer Focused Health Plan NetworkBLUE (Broad Network)	Consumer Focused Health Plan Premier Select BlueChoice (Narrow Network)	Consumer Focused Health Plan Blueprint Health (Narrow Network)
Employee Only (Single Coverage)	Your Cost:	\$370.20	\$315.00	\$315.00	\$218.46	\$185.90	\$185.90
	State Cost:	\$705.96	\$600.72	\$600.72	\$416.60	\$354.54	\$354.54
	Total:	\$1,076.16	\$915.72	\$915.72	\$635.06	\$540.44	\$540.44
Employee + Spouse (Two-Party Coverage)	Your Cost:	\$981.00	\$834.76	\$834.76	\$578.92	\$492.66	\$492.66
	State Cost:	\$1,870.76	\$1,591.90	\$1,591.90	\$1,103.98	\$939.50	\$939.50
	Total:	\$2,851.76	\$2,426.66	\$2,426.66	\$1,682.90	\$1,432.16	\$1,432.16
Employee + Dependent Children (Four-Party Coverage)	Your Cost:	\$758.90	\$645.76	\$645.76	\$447.84	\$381.12	\$381.12
	State Cost:	\$1,447.20	\$1,231.48	\$1,231.48	\$854.06	\$726.80	\$726.80
	Total:	\$2,206.10	\$1,877.24	\$1,877.24	\$1,301.90	\$1,107.92	\$1,107.92
Employee + Spouse + Dependent Children (Family Coverage)	Your Cost:	\$1,314.18	\$1,118.26	\$1,118.26	\$775.52	\$659.98	\$659.98
	State Cost:	\$2,506.10	\$2,132.52	\$2,132.52	\$1,478.94	\$1,258.58	\$1,258.58
	Total:	\$3,820.28	\$3,250.78	\$3,250.78	\$2,254.46	\$1,918.56	\$1,918.56