Schedule of Benefits Summary

Group Name: University Of Nebraska

Effective Date: January 01, 2025

Payment for Services	Tier I Enhanced Network Provider	Tier II In-Network	Tier III 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. 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.			
Enhanced Network benefits are available when a Covered Person under this Plan receives Covered Services from an Enhanced Network Tier Provider. Not all Covered Services shown on this document are available from an Enhanced Network Provider. Tier II providers are shown on your I.D. card. For help in locating In-network Providers, visit NebraskaBlue.com/Find-A-Doctor 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. Please 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	 $1,350 $2,600	 $1,550 $3,100	 $1,950 $3,900
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays • Plan Pays	 15% 85%	 30% 70%	 45% 55%
Coinsurance Limit (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Individual • Family	 $2,300 $4,700	 $2,500 $5,000	 $2,900 $5,800
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays) • Individual • Family	 $3,650 $7,300	 $4,050 $8,100	 $4,850 $9,700
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. Day, session or visit limits for certain services shown on this summary are not applicable to Mental Health and/or Substance Use Disorders. 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 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: • This plan has no medical or prescription drug copays 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 please visit NebraskaBlue.com/PreAuth			

Covered Services – Illness or Injury	Tier I Enhanced Network Provider	Tier II In-Network	Tier III Out-of-Network Provider
Physician Office • Primary Care Physician Office Visit • Other Injections	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Telehealth Services • Medical • Mental Health	Deductible and Coinsurance See Mental Health and/or Substance Use Disorder Services	Tier I In-network level of benefits See Mental Health and/or Substance Use Disorder Services	Tier I In-network level of benefits See Mental Health and/or Substance Use Disorder Services
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services	Deductible and Coinsurance	Deductible and Coinsurance	Tier II In-network level of benefits
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance	Tier II In-network level of benefits Tier II In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

NOTE: Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See NebraskaBlue.com/PreferredCenters for a list of Covered Services and designated hospitals.

Preventive Services	Tier I Enhanced Network Provider	Tier II In-Network	Tier III Out-of-Network Provider
Preventive Services (Regular Benefits) • Under age 2 Services include periodic exams, office visits, radiology, x-rays, pathology and laboratory • Immunizations for Children up to Age 7	Plan Pays 100%		
• Age 2 and above Services include physical exams, pap smears, hearing examinations, radiology, laboratory testing, cardiac stress tests • Immunizations for Children Age 7 and Older	Plan Pays 100% up to $250 per person per Calendar Year, then applicable Deductible and Coinsurance		
Colorectal Cancer Screenings (starting at age 45) • Colonoscopy Screening - Diagnostic or Preventive Screening (one every five years) - Screenings outside the age or frequency limit • Sigmoidoscopy/Proctoscopy Screening and CT of the Colon - Preventive Screening (one every five years) - Screenings outside the age or frequency limit • FIT DNA - Preventive Screening (one every three years) - Screenings outside the age or frequency limit • Fecal occult blood test - Preventive Screening (one per year) - Screenings outside the age or frequency limit • Barium enema and other tests as determined under ACA Preventive Services - Preventive Screenings - Diagnostic Screenings	Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness	Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance 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. **NOTE:** Covered Services for colonoscopies in excess of one every 5 years by either an In-network or Out-of-network provider will be subject to the applicable Deductible and Coinsurance.			
Mammograms (2/D 3/D) including technical and professional interpretation fees • Preventive • Diagnostic	Plan Pays 100% Deductible and Coinsurance	Plan Pays 100% Deductible and Coinsurance	Plan Pays 100% Deductible and Coinsurance
NOTE: Covered Services for Preventive Mammograms in excess of one per calendar year by either an In-network or Out-of-network provider will be subject to the applicable Deductible and Coinsurance.			

Mental Health and Substance Use Disorders Covered Services	Tier I Enhanced Network Provider	Tier II In-Network	Tier III Out-of-Network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services • Office Visit • Telehealth Services • All Other Outpatient Items & Services	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Tier I In-network level of benefits Deductible and Coinsurance	 Deductible and Coinsurance Tier I In-network level of benefits Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance	 Tier II In-network level of benefits Tier II In-network level of benefits
Other Covered Services – Illness or Injury	**Tier I Enhanced Network Provider**	**Tier II In-Network**	**Tier III Out-of-Network Provider**
Acupuncture	Not Covered	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Allergy Injections and Serums	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	 Deductible and Coinsurance Deductible and Coinsurance	 Tier II In-network level of benefits Tier II 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	 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	 Deductible and Coinsurance Same as mental health
Dermatological Services	Same as any other illness	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	Same as any other illness	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	Deductible and Coinsurance

Other Covered Services – Illness or Injury	Tier I Enhanced Network Provider	Tier II In-Network	Tier III Out-of-Network Provider
Hearing Services			
• Hearing Aids (up to age 19 limited to $3,000 every 48 months)	Same as any other illness	Same as any other illness	Same as any other illness
Home Health Care			
• Home Health Aid and Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Qualified Dietician	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Respiratory Care (limited to 60 visits per calendar year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory			
• Diagnostic	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Preventive	Same as Preventive Services	Same as Preventive Services	Same as Preventive Services
Infertility			
• Services to diagnose	Same as any other illness	Same as any other illness	Deductible and Coinsurance
• Treatment to promote fertility (combined $15,000 medical and prescription drug limit)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Nicotine Addiction			
• Medical services and therapy	Not Covered	Not Covered	Not Covered
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered	Not Covered
Obesity			
• Non-surgical treatment	Not Covered	Not Covered	Not Covered
• Surgical Treatment	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	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)	Tier II In-network Level of benefits	Deductible and Coinsurance	Tier II In-network Level of benefits
- Transportation and lodging required for travel to a Blue Distinction Center for the covered surgical procedure for the Covered Person and one companion	Tier II In-network Level of benefits	Deductible and Coinsurance	Tier II In-network Level of benefits
• Transplant Surgical Services (not part of the Blue Distinction transplant program)	Same as any other illness	Same as any other illness	Same as any other illness
- Transportation and lodging required for travel for a covered surgical procedure for the Covered Person and one companion.	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
• Preoperative and postoperative Services (not included in the above provisions)	Same as any other illness	Same as any other illness	Same as any other illness

Other Covered Services – Illness or Injury	Tier I Enhanced Network Provider	Tier II In-Network	Tier III Out-of-Network Provider
Orthotics (prescription only)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Other Injections	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance	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) • Newborn care	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Initial newborn Facility	Coinsurance	Coinsurance	Coinsurance
• Physician	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions. **NOTE:** The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.			
Breast Feeding Services • Breast pump and supplies (limited to one per pregnancy)	Plan Pays 100%		
• Lactation support and counseling	Plan Pays 100% Out-of-network Providers may bill for amounts over the Out-of-network Allowance.		
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation (limited to 36 sessions per diagnosis per Calendar Year) • Pulmonary Rehabilitation (is limited to 36 sessions per diagnosis for certain diagnoses under the following circumstances)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
- Chronic lung disease	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
- Lung transplant during the preceding four months	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
- Heart lung transplant during the preceding four months	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
- Preoperative and postoperative care for lung reduction volume surgery	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	Tier I Enhanced Network Provider	Tier II In-Network	Tier III Out-of-Network Provider
Sexual Dysfunction	Not Covered	Not Covered	Not Covered
Skilled Nursing Facility (including rehabilitation services at an Inpatient Facility) (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Not Covered	Not Covered	Not Covered
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy and chiropractic or osteopathic manipulative treatments or adjustments	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Note: Medical Necessity Will Be Reviewed After 60 Combined Visits for Manipulations, Occupational, Physical and Speech Therapy. **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 • Eye Glasses or Contact Lenses	Not Covered	Not Covered	Not Covered
• Cataract or Aphakia Surgery (including surgically implanted conventional intraocular cataract lenses, following such procedure)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Note: Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are covered subject to deductible and coinsurance.			
• Vision Exam - Diagnostic, including refractions (to diagnose an illness)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
- Preventive (routine exam including refraction)	Not Covered	Not Covered	Not Covered
Wigs	Not Covered	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

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.