

# 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
<p>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.</p>			
<p><b>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 a Enhanced Network Provider. Tier II providers are shown on your I.D. card. For help in locating In-network Providers, visit <a href="http://NebraskaBlue.com/Find-A-Doctor">NebraskaBlue.com/Find-A-Doctor</a></b> 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.</p>			
<p><b>Deductible</b> (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	<p>\$200 \$400</p>	<p>\$300 \$600</p>	<p>\$450 \$900</p>
<p><b>Coinsurance</b> (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> <li>Covered Person Pays</li> <li>Plan Pays</li> </ul>	<p>10% 90%</p>	<p>20% 80%</p>	<p>35% 65%</p>
<p><b>Coinsurance Limit</b> (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	<p>\$1,300 \$2,600</p>	<p>\$1,400 \$2,800</p>	<p>\$1,700 \$3,400</p>
<p><b>Out-of-pocket Limit</b> (Includes Deductible, Coinsurance and Copays)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	<p>\$1,500 \$3,000</p>	<p>\$1,700 \$3,400</p>	<p>\$2,150 \$4,300</p>
<p>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.</p>			
<p>*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.</p>			
<p><b>Copayment(s) (copay(s)) apply to:</b></p> <ul style="list-style-type: none"> <li>This plan has no medical or prescription drug copays</li> </ul> <p>The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.</p>			
<p><b>Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits. For additional information regarding Preauthorization procedures please visit <a href="http://NebraskaBlue.com/PreAuth">NebraskaBlue.com/PreAuth</a></b></p>			

<b>Covered Services – Illness or Injury</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary Care Physician Office Visit</li> <li>Other Injections</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
<b>Telehealth Services</b> <ul style="list-style-type: none"> <li>Medical</li> <li>Mental Health</li> </ul>	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
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a Primary Care Physician	Same as a Primary Care Physician	Deductible and Coinsurance
<b>Urgent Care Facility Services</b>	Deductible and Coinsurance	Deductible and Coinsurance	Tier II In-network level of benefits
<b>Emergency Care Services</b> (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul>	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
<b>Outpatient Hospital or Facility Services</b> 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
<b>Inpatient Hospital or Facility Services</b> 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
<b>Orthopedic Specialty Hospital or Facility Services</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>NOTE:</b> Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See <a href="http://NebraskaBlue.com/PreferredCenters">NebraskaBlue.com/PreferredCenters</a> for a list of Covered Services and designated hospitals.			

<b>Preventive Services</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Preventive Services</b> (Regular Benefits) <ul style="list-style-type: none"> <li>Under age 2 Services include periodic exams, office visits, radiology, x-rays, pathology and laboratory</li> <li>Immunizations for Children up to Age 7</li> </ul>	Plan Pays 100%		
<ul style="list-style-type: none"> <li>Age 2 and above Services include physical exams, pap smears, hearing examinations, radiology, laboratory testing, cardiac stress tests</li> <li>Immunizations for Children Age 7 and Older</li> </ul>	Plan Pays 100% up to \$250 per person per Calendar Year, then applicable Deductible and Coinsurance		
<b>Colonoscopy and related Services</b> (Regular Benefits)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Mammograms (2/D 3/D)</b> including technical and professional interpretation fees <ul style="list-style-type: none"> <li>Preventive</li> <li>Diagnostic</li> </ul>	Plan Pays 100% Deductible and Coinsurance	Plan Pays 100% Deductible and Coinsurance	Plan Pays 100% Deductible and Coinsurance
<b>NOTE:</b> 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.			
<b>Mental Health and Substance Use Disorders Covered Services</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Inpatient Services</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>Office Visit</li> <li>Telehealth Services</li> <li>All Other Outpatient Items &amp; Services</li> </ul>	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
<b>Emergency Care Services</b> (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul>	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

<b>Other Covered Services – Illness or Injury</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Acupuncture</b>	Not Covered	Not Covered	Not Covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Allergy Injections and Serums</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground Ambulance</li> <li>• Air Ambulance</li> </ul>	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
<b>Autism Spectrum Disorder</b> <ul style="list-style-type: none"> <li>• Testing and Diagnosis</li> <li>• Treatment</li> </ul>	Same as Mental Health Same as Mental Health	Same as Mental Health Same as Mental Health	Same as Mental Health Same as Mental Health
<b>Biofeedback</b> <ul style="list-style-type: none"> <li>• Medical</li> <li>• Mental Health</li> </ul>	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment.	Same as any other illness	Same as any other illness	Deductible and Coinsurance
<b>Durable Medical Equipment and Supplies (including Prosthetics)</b> (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

<b>Other Covered Services – Illness or Injury</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>Hearing Aids (up to age 19 limited to \$3,000 every 48 months)</li> </ul>	Same as any other illness	Same as any other illness	Same as any other illness
<b>Home Health Care</b> <ul style="list-style-type: none"> <li>Home Health Aid and Nursing Care (limited to 8 hours per day)</li> <li>Home Infusion Therapy</li> <li>Qualified Dietician</li> <li>Respiratory Care (limited to 60 visits per calendar year)</li> </ul>	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 Deductible and Coinsurance Deductible and Coinsurance
<b>Hospice Services</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>Diagnostic</li> <li>Preventive</li> </ul>	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services
<b>Infertility</b> <ul style="list-style-type: none"> <li>Services to diagnose</li> <li>Treatment to promote fertility (combined \$15,000 medical and prescription drug limit)</li> </ul>	Same as any other illness  Deductible and Coinsurance	Same as any other illness  Deductible and Coinsurance	Deductible and Coinsurance  Deductible and Coinsurance
<b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical services and therapy</li> <li>Nicotine addiction classes &amp; alternative therapy, such as acupuncture</li> </ul>	Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered
<b>Obesity</b> <ul style="list-style-type: none"> <li>Non-surgical treatment</li> <li>Surgical Treatment</li> </ul>	Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered
<b>Oral Surgery and Dentistry</b> 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
<b>Organ and Tissue Transplantation</b> <ul style="list-style-type: none"> <li>Transplant Surgical Services – Designated transplant at a Blue Distinction Center (limited to the day before, surgery, and confinement)               <ul style="list-style-type: none"> <li>Transportation and lodging required for travel to a Blue Distinction Center for the covered surgical procedure for the Covered Person and one companion</li> </ul> </li> <li>Transplant Surgical Services (not part of the Blue Distinction transplant program)               <ul style="list-style-type: none"> <li>Transportation and lodging required for travel for a covered surgical procedure for the Covered Person and one companion.</li> </ul> </li> <li>Preoperative and postoperative Services (not included in the above provisions)</li> </ul>	Tier II In-network Level of benefits  Tier II In-network Level of benefits  Same as any other illness  Plan Pays 100%  Same as any other illness	Deductible and Coinsurance  Deductible and Coinsurance  Same as any other illness  Plan Pays 100%  Same as any other illness	Tier II In-network Level of benefits  Tier II In-network Level of benefits  Same as any other illness  Plan Pays 100%  Same as any other illness

<b>Other Covered Services – Illness or Injury</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Orthotics</b> (prescription only)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Ostomy Supplies</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Other Injections</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Physician Professional Services</b> 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
<b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>• Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>• Newborn care</li> <li>• Initial newborn Facility</li> <li>• Physician</li> </ul> <p><b>NOTE:</b> Newborns are covered at birth, subject to the plan’s enrollment provisions.  <b>NOTE:</b> The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.</p>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Brest Feeding Services</b> <ul style="list-style-type: none"> <li>• Breast pump and supplies (limited to one per pregnancy)</li> <li>• Lactation support and counseling</li> </ul>		Plan Pays 100%	Plan Pays 100%
		Out-of-network Providers may bill for amounts over the Out-of-network Allowance.	
<b>Radiation Therapy and Chemotherapy</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Radiology (X-ray) Services and Other Diagnostic Tests</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation (limited to 36 sessions per diagnosis per Calendar Year)</li> <li>• Pulmonary Rehabilitation (is limited to 36 sessions per diagnosis for certain diagnoses under the following circumstances) <ul style="list-style-type: none"> <li>- Chronic lung disease</li> <li>- Lung transplant during the preceding four months</li> <li>- Heart lung transplant during the preceding four months</li> <li>- Preoperative and postoperative care for lung reduction volume surgery</li> </ul> </li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Renal Dialysis</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

<b>Other Covered Services – Illness or Injury</b>	<b>Tier I Enhanced Network Provider</b>	<b>Tier II In-Network</b>	<b>Tier III Out-of-Network Provider</b>
<b>Sexual Dysfunction</b>	Not Covered	Not Covered	Not Covered
<b>Skilled Nursing Facility</b> (including rehabilitation services at an Inpatient Facility) (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Sleep Studies</b>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Not Covered	Not Covered	Not Covered
<b>Therapy &amp; Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy and chiropractic or osteopathic manipulative treatments or adjustments</li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
<p><b>Note:</b> Medical Necessity Will Be Reviewed After 60 Combined Visits for Manipulations, Occupational, Physical and Speech Therapy.  <b>Note:</b> 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.</p>			
<b>Vision Services</b> <ul style="list-style-type: none"> <li>Eye Glasses or Contact Lenses</li> <li>Cataract or Aphakia Surgery (including surgically implanted conventional intraocular cataract lenses, following such procedure)</li> </ul>	Not Covered	Not Covered	Not Covered
<p><b>Note:</b> Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are covered subject to deductible and coinsurance.</p>			
<ul style="list-style-type: none"> <li>Vision Exam <ul style="list-style-type: none"> <li>- Diagnostic, including refractions (to diagnose an illness)</li> <li>- Preventive (routine exam including refraction)</li> </ul> </li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
	Not Covered	Not Covered	Not Covered
<b>Wigs</b>	Not Covered	Not Covered	Not Covered
<b>All Other Covered Services</b>	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.