# Schedule of Benefits Summary

Group Name: University Of Nebraska

Effective Date: January 1, 2027

| Payment for Services | Tier I Enhanced Network Provider | Tier II 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. | | | |
| **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 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**<br>(the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)<br>• Individual<br>• Family (Embedded*) | <br><br>$3,500<br>$7,000 | <br><br>$3,500<br>$7,000 | <br><br>$7,000<br>$14,000 |
| **Coinsurance**<br>(the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)<br>• Covered Person Pays<br>• Plan Pays | <br><br>0%<br>100% | <br><br>20%<br>80% | <br><br>30%<br>70% |
| **Coinsurance Limit**<br>(the amount the Covered Person must pay for most Covered Services after the Deductible has been met)<br>• Individual<br>• Family (Embedded*) | <br><br>$0<br>$0 | <br><br>$800<br>$1,700 | <br><br>$1,500<br>$3,000 |
| **Out-of-pocket Limit**<br>(includes Deductible, Coinsurance and Copayments)<br>• Individual<br>• Family (Embedded*) | <br><br>$3,500<br>$7,000 | <br><br>$4,300<br>$8,700 | <br><br>$8,500<br>$17,000 |
| 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:**<br>• This Plan has no medical or prescription drug copays.<br><br>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.**<br>**For additional information regarding Preauthorization procedures visit NebraskaBlue.com/PreAuth.** | | | |

| Covered Services – Illness or Injury | Tier I Enhanced Network Provider | Tier II In-network Provider | Out-of-network Provider |
|---|---|---|---|
| **Primary Care Physician Office Visit** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| **Specialist Physician Office Visit** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| **Telehealth/Virtual Care Services**<br>• Medical<br>• Mental Health | Deductible then Plan Pays 100%<br>See Mental Health and/or Substance Use Disorder Services | Tier I In-network level of benefits<br>See Mental Health and/or Substance Use Disorder Services | Tier I In-network level of benefits<br>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 Room Services**<br>• Facility<br>• Professional Services | Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br>Deductible and Coinsurance | Tier II In-network level of benefits<br>Tier II 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 | 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 | Deductible and Coinsurance |
| **Orthopedic Specialty Hospital or Facility Services** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |

**NOTE:** 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 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% | Plan Pays 100% | Deductible and Coinsurance |
| • ACA required covered preventive services (outside of limits) | Same as any other illness | Same as any other illness | Deductible and Coinsurance |
| • Other covered preventive services not required by ACA | Same as any other illness | Same as any other illness | Deductible and Coinsurance |
| For additional information please visit NebraskaBlue.com/PreventiveCare | | | |
| **Immunizations** | | | |
| • Pediatric (up to age 7) | Plan Pays 100% | Plan Pays 100% | Deductible and Coinsurance |
| • Age 7 and older | Plan Pays 100% | Plan Pays 100% | Deductible and Coinsurance |
| • Related to an illness | Same as any other 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% | Plan Pays 100% | Deductible and Coinsurance |
| - Screenings outside the age or frequency limit | Same as any other Illness | 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% | Plan Pays 100% | Deductible and Coinsurance |
| - Screenings outside the age or frequency limit | Same as any other Illness | Same as any other Illness | Deductible and Coinsurance |
| • FIT DNA | | | |
| - Preventive Screening (one every three years) | Plan Pays 100% | Plan Pays 100% | Deductible and Coinsurance |
| - Screenings outside the age or frequency limit | Same as any other Illness | Same as any other Illness | Deductible and Coinsurance |
| • Fecal Occult Blood Test | | | |
| - Preventive Screening (one per year) | Plan Pays 100% | Plan Pays 100% | Deductible and Coinsurance |
| - Screenings outside the age or frequency limit | Same as any other Illness | Same as any other Illness | Deductible and Coinsurance |
| • Barium Enema, and other tests as determined under ACA Preventive Services | | | |
| - Preventive Screenings | Plan Pays 100% | Plan Pays 100% | Deductible and Coinsurance |
| - Diagnostic Screenings | Same as any other Illness | 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. | | | |
| **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 | Plan Pays 100% | Plan Pays 100% | Plan Pays 100% |
| • Diagnostic | Deductible and Coinsurance | Deductible and Coinsurance | 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/or Substance Use Disorder Services | Tier I Enhanced Network Provider | Tier II In-network Provider | Out-of-network Provider |
|---|---|---|---|
| **Office Visit** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| **All Other Outpatient Items and Services** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| **Telehealth/Virtual Care Services** | Deductible and Coinsurance | Tier I In-network level of benefits | Tier I In-network level of benefits |
| **Emergency Room Services** | | | |
| • Facility | Deductible and Coinsurance | Deductible and Coinsurance | Tier II In-network level of benefits |
| • Professional Services | Deductible and Coinsurance | Deductible and Coinsurance | Tier II In-network level of benefits |
| **Inpatient Services** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| **For additional resources and support visit NebraskaBlue.com/MentalHealth** | | | |
| **Other Covered Services – Illness or Injury** | **Tier I Enhanced Network Provider** | **Tier II In-network Provider** | **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 | Deductible and Coinsurance | Deductible and Coinsurance | Tier II In-network level of benefits |
| • Air Ambulance | Deductible and Coinsurance | Deductible and Coinsurance | Tier II In-network level of benefits |
| **Autism Spectrum Disorder** | | | |
| • Testing and Diagnosis | Same as Mental Health | Same as Mental Health | Same as Mental Health |
| • Treatment | Same as Mental Health | Same as Mental Health | Same as Mental Health |
| **Biofeedback** | | | |
| • Medical | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| • Mental Health | Same as Mental Health | Same as Mental Health | 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 |
| **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 | Same as any other Illness |
| **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 |
| **Hearing Services** | | | |
| • Hearing Aids and related Services (up to age 19, limited to $3,000 every 48 months) | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |

| Other Covered Services – Illness or Injury | Tier I Enhanced Network Provider | Tier II In-network Provider | Out-of-network Provider |
|---|---|---|---|
| **Home Health Care Services** | | | |
| • Home Health Aide 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 |
| • Respiratory Care (limited to 60 visits per Calendar Year) | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| • Qualified Dietician | 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 Provider | 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** 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 | Deductible and Coinsurance |
| **Pregnancy, Maternity and Newborn Care**<br>• Pregnancy and maternity<br>Visits<br>All Other Services<br>• Newborn care<br>- Initial newborn Facility<br>- Physician | <br><br>Plan Pays 100%<br>Deductible and Coinsurance<br><br>Deductible and Coinsurance<br>Deductible and Coinsurance | <br><br>Plan Pays 100%<br>Deductible and Coinsurance<br><br>Deductible and Coinsurance<br>Deductible and Coinsurance | <br><br>Deductible and Coinsurance<br>Deductible and Coinsurance<br><br>Deductible and Coinsurance<br>Deductible and Coinsurance |
| **NOTE**: Newborns are covered at birth, subject to the plan's enrollment provisions.<br>**NOTE:** The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth. | | | |
| **Breast Feeding Services**<br>• Breast pump and supplies (limited to one per pregnancy)<br>• Lactation support and counseling | Plan Pays 100%<br>Plan Pays 100%<br>Out-of-network Providers may bill for amounts over the Out-of-network Allowance. | | Deductible and Coinsurance<br>Deductible and Coinsurance |
| **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**<br>• Cardiac rehabilitation (limited to 36 sessions per diagnosis per Calendar Year)<br>• Pulmonary Rehabilitation (is limited to 36 sessions per diagnosis for certain diagnoses under the following circumstances)<br>- Chronic lung disease<br>- Lung transplant during the preceding four months<br>- Heart lung transplant during the preceding four months<br>- Preoperative and postoperative care for lung reduction volume surgery | Deductible and Coinsurance<br><br><br><br><br><br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br><br><br><br><br><br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br><br><br><br><br><br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance |
| **Renal Dialysis** | Deductible and Coinsurance | Deductible and Coinsurance | Deductible and Coinsurance |
| **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 |

| Other Covered Services – Illness or Injury | Tier I Enhanced Network Provider | Tier II In-network Provider | Out-of-network Provider |
|---|---|---|---|
| **Therapy & Manipulations**<br>• 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.<br>**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**<br>• 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. | | | |
| **Eye Exam**<br>• 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 |

| Pharmacy Services |
|---|
| **Pharmacy Benefits are carved out to EmpiRx Health. For additional information contact EmpiRx Health Customer Service at 1-833-419-3436 or visit www.myempirxhealth.com.** |

**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.