SignatureBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

University of Nebraska

Effective Date: January 01, 2027

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 Non-covered 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.		
Deductible (the amount the Covered Person pays each Calendar Year for combined Covered Services before the Coinsurance is payable)		
• B, C Services	**$35**	**$45**
• D Services	**$40**	**$50**
Calendar Year Maximum Benefit (the calendar year amount payable for combined Covered Services for each Covered Person while covered under this plan)	**$1,500**	**$1,500**
Calendar Year Maximum Benefit applies to the following Coverage benefits:	**A, B, C Services**	**A, B, C Services**
Total Maximum Benefit (the total amount payable for Covered Services for each Covered Person while covered under this plan)	**$2,000**	**$2,000**
Total Maximum Benefit applies to the following Coverage benefits:	**D Services**	**D Services**
Coverage For Dental Services (Coinsurance shown below is the percentage the Covered Person must pay)		
Coverage A	**15%**	**20%**
Coverage B	**15%**	**20%**
Coverage C	**50%**	**50%**
Coverage D	**50%**	**50%**
Coverage E	**Not Covered**	**Not Covered**
Blue Cross Blue Shield of Nebraska Enhanced Benefits Program Included.		

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.

This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. Your Dental benefits may include but are not limited the following benefits

Coverage A – Preventive and Diagnostic

- **Comprehensive and/or periodic oral exams** *two every calendar year*
- **Consultations**
- **Prophylaxis (cleaning, scaling and polishing)** *two every calendar year*
- **Topical fluoride** *two every calendar year for Covered Persons up to age 16*
- **Sealants (permanent first and second molar teeth)** *once every four calendar years for Covered Persons up to age 16*
- **Pulp vitality test**
- **X-rays (intraoral, bitewing, occlusal, periapical, extraoral)**
  - Full mouth or panorex series *one every three consecutive calendar years*
  - Supplemental bitewing *one set of four every calendar year*
  - Vertical bitewing *once every 3 years*
- **Space maintainers** *for Covered Persons up to age 16*
- **Fluoride varnishes** *two every calendar year*

Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontics, Endodontics

- **Oral surgery**
  - Simple and impacted extractions
  - Alveoplasty
  - Removal of dental cysts and tumors
  - Surgical incision and drainage of dental abscess
  - Tooth replantation
  - Excision of hyperplastic tissue
- **General anesthesia**
- **Restorations, except gold restorations**
- **Palliative treatment**
- **Dry socket treatment**
- **Repair of dentures, bridges, crowns and cast restorations**
- **Emergency oral examinations**
- **Pre-formed stainless steel or acrylic crowns**
- **Recement inlays and crowns**
- **Occlusal guard** *limited to 1 every 3 years*
- **Endodontic services (treatment of diseases or injuries of pulp chambers, root canals and periapical tissue)**
  - Pulp cap
  - Vital pulpotomy
  - Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow up care)
  - Apical curettage
  - Root resection and hemisection
- **Periodontic services (treatment of diseases of gums and supporting tooth structure)**
  - Periodontic cleanings *four every calendar year*
  - Gingivectomy and gingival curettage *limited to 1 time per quadrant every 3 years*
  - Osseous surgery and graft *limited to 1 time per quadrant every 3 years*
  - Scaling and root planing *limited to 1 time per quadrant every 2 years*
  - Periodontal splinting
  - Mucogingivoplastic surgery
  - Treatment of acute infection and oral lesions
  - Full mouth debridement limited to 1 every 5 years

Coverage C – Complex Restorative Dentistry

- **Crowns** *1 per tooth every 5 years*
- **Temporary crown (within 72 hours of accident)**
- **Inlays when used as abutments for fixed bridgework** *1 per tooth every 5 years*
- **Installation of permanent bridges** *1 per tooth every 5 years*
- **Cast post and core in addition to crown**
- **Core buildup**
- **Dentures – full and partial** *1 every 5 years*
- **Denture adjustments** *after six months from date of installation*
- **Denture relining** *1 every 3 years after six months from date of installation*

Coverage D – Orthodontic Dentistry

- **Cephalometric x-rays**
- **Extractions**
- **Casts and models**
- **Orthodontic appliances** (initial and subsequent installations)
- **Surgical exposure to aid eruption**

Coverage E – Temporomandibular Joint Diagnosis and Treatment (NOT COVERED)

- **Treatment for occlusal equilibration** (grinding of teeth)
- **Open and closed operative procedures**
- **TMJ x-rays**
- **Initial and subsequent installation of appliances and treatment**