Coverage Period: 1/1/2025 - 12/31/2025 Coverage for: Individual/Family | Plan Type: PPO

**HSA-Eligible** 

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>www.NebraskaBlue.com</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.cciio.cms.gov</u> or call 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family Select In-Network: \$3,300/\$6,600 In-Network: \$3,300/\$6,600 Out-of-Network: \$6,600/\$13,200	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your deductible?	Yes, <u>preventive care</u> and <u>prescription</u> <u>drugs</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet

<u>In-Network</u>: \$4,100/\$8,300 <u>Out-of-Network</u>: \$8,100/\$16,200 The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your overall <u>deductible</u> has been met, if a <u>deductible</u> applies. Certain Common Medical Events, including <u>prescription drugs</u>, may require <u>preauthorization</u>. Failure to obtain <u>preauthorization</u> will result in denial of the <u>claim</u>.

	9		What You Will Pay		
Common Medical Event	Services You May Need	Select In-Network Provider (You will pay the least)	Los Miladoros allo	Out-of-Network Provider (You will	Limitations, Exceptions, & Other Important Information

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

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University of Nebraska					Coverage Period: 1/1/2025 - 12/31/2025
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ı	University of Nebraska			Coverage Period: 1/1/2025 - 12/31/2025		
ı				What You Will Pay		
	Common Medical Event	Services You May Need	Select In-Network Provider (You will pay the least)	I I NI I I	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Children's glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
		Children's dental check-up	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

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About these Coverage Examples:

■ The <u>plan's</u> overall <u>deductible</u>	\$3,300
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

<u>Specialist</u> office visits (*prenatal care*)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

<u>Diagnostic tests</u> (*ultrasounds and blood work*)

Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	

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■ The <u>plan's</u> overall <u>deductible</u>	\$3,30
Specialist coinsurance	09
Hospital (facility) coinsurance	09
Other <u>coinsurance</u>	09

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (*blood work*)

<u>Prescription drugs</u>

<u>Durable medical equipment</u> (*glucose meter*)

	Total Example	Cost	\$5,600
n	this example	loe would nav	

The plan's over the plan's	verall <u>deductible</u>	\$3,300
Specialist coi	<u>nsurance</u>	0%
Hospital (fac	cility) <u>coinsurance</u>	0%
Other coinsu	irance	0%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

<u>Diagnostic test</u> (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy,	)
Total Evample Cost	\$2,800

	Total Example Cost	\$2,000
In	this example, Mia would pay:	

The <u>plan</u> would be responsible for the other costs of the EXAMPLE covered services.

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