

Schedule of Benefits Summary

Group Name: Triage, LLC Effective Date: January 1, 2026

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 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.

In-network Provider: The 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.

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Deductible		
(the amount the Covered Person pays each Calendar		
Year for Covered Services before the Coinsurance is		
payable)		
 Individual 	\$8,500	\$17,000
 Family (Embedded*) 	\$17,000	\$34,000
Coinsurance		
(the percentage amount the Covered Person must pay		
for most Covered Services after the Deductible has		
been met)		
Covered Person Pays	0%	0%
Plan Pays	100%	100%
Out-of-pocket Limit		
(includes Deductible, Coinsurance and Copayments)		
Individual	\$8,500	\$17,000
 Family (Embedded*) 	\$17,000	\$34,000

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not 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:

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 visit NebraskaBlue.com/PreAuth.

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider	
Primary Care Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance	
Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance	
Benefits for Primary Care Physician or Specialist Physician office visit include the office visit (including the initial visit to diagnose Pregnancy), consultations and medication checks.			
Allergy Injections and Serum (only one Copay applies per day per provider)	Deductible and Coinsurance	Deductible and Coinsurance	
Other Injections	Deductible and Coinsurance	Deductible and Coinsurance	
Physician Office Services	Deductible and Coinsurance	Deductible and Coinsurance	

The following Physician Office Services are available when provided in a Primary Care Physician or Specialist Physician's office, with or without an office visit; X-rays, laboratory and pathology Services, supplies and/or drugs administered during the office visit, hearing exams or eye exams (excluding refractions) due to Illness or Injury.

Other Services provided in the office but NOT included in the Physician's office visit or Physician office Services benefit listed above, include but are not limited to; Preventive Services, Mental Health and/or Substance Use Disorder Services, Biofeedback, Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine), Durable Medical Equipment, Pregnancy, Maternity and Newborn Care, Radiation Therapy and Chemotherapy, Sleep Studies, Therapy and **Manipulations** and Surgery and Anesthesia. (Refer to the appropriate categories below and your benefit book for additional information.)

Telehealth/Virtual Care Services		
 Medical 	Deductible and Coinsurance	Not Covered
Mental Health	See Mental Health and/or Substance Use Disorder Services	Not Covered
Convenient Care/Retail Clinics/Quick Care	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room Services		
 Facility 	Deductible and Coinsurance	In-network level of benefits
 Professional Services 	Deductible and Coinsurance	In-network level of benefits
Outpatient Hospital or Facility Services		
Services include but are not limited to surgery,	Deductible and Coinsurance	Deductible and Coinsurance
laboratory and radiology, observation stays, and	Deductible and Comsulance	Deductible and Comsulance
other Services provided on an Outpatient basis.		
Inpatient Hospital or Facility Services		
Services include but are not limited to charges for		
room and board, diagnostic testing, rehabilitation	Deductible and Coinsurance	Deductible and Coinsurance
Services and other ancillary Services provided on an		
Inpatient basis.		
Orthopedic Specialty Hospital or Facility	Deductible and Coinsurance	Deductible and Coinsurance
Services	Deductible and comsulance	Deductible and Comburance
NOTE: Daduatibles and Cainauranes may be waited if	Covered Comisee are musided at a decision	tad Duafausad Cantau Caa

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.

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reventive Services	In-network Provider	Out-of-network Provider
reventive Services		
 Affordable Care Act (ACA) required 		
Preventive Services (may be subject to	Plan Paya 1000/	Deductible and Coinsurance
limits that include but are not limited to	Plan Pays 100%	Deductible and Coinsurance
age, gender, and frequency)		
 ACA-required covered Preventive Services 	Plan Pays 100%	Deductible and Coinsurance
(outside of limits)	1 Idil 1 dys 100 /0	Deductible and Comsulance
 Other covered Preventive Services not 		
required by ACA, such as:		
 Laboratory tests as specified by Us, 		
including urinalysis and complete	BL B 4000/	5 1 211 10 1
blood count; general health panel;	Plan Pays 100%	Deductible and Coinsurance
metabolic panel; prostate cancer		
screening (PSA) and hearing exams		
- All other laboratory tests; radiology,		
cardiac stress tests; EKG; pulmonary	Same as any other Illness	Same as any other Illness
function and other screenings and services		
services or additional information visit <u>NebraskaBlue.com/Pre</u>	 ventiveCare	
nmunizations		
Pediatric (up to age 7)	Plan Pays 100%	Coinsurance
 Age 7 and older 	Plan Pays 100%	Deductible and Coinsurance
Related to an Illness	Same as any other Illness	Same as any other Illness
plorectal Cancer Screenings (starting at age 45)	came as any same miness	game as any sais. imisso
Colonoscopy Screening		
- Diagnostic or Preventive Screening	DI D 4000/	D 1 (11 10 :
(one every five years)	Plan Pays 100%	Deductible and Coinsurance
 Screenings outside the age or 	Sama as any other Illness	Deductible and Coinsurance
frequency limit	Same as any other Illness	Deductible and Comsulance
 Sigmoidoscopy/Proctoscopy Screening and 		
CT of the Colon		
 Preventive Screening (one every five 	Plan Pays 100%	Deductible and Coinsurance
years)	1 14.11 4 4 6 1 6 6 7 8	Boddottbio dila combaranco
- Screenings outside the age or	Same as any other Illness	Deductible and Coinsurance
frequency limit	,	
 FIT DNA Preventive Screening (one every three 		
years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or		
frequency limit	Same as any other Illness	Deductible and Coinsurance
Fecal Occult Blood Test		
- Preventive Screening (one per year)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or	·	Deductible and Coinsurance
frequency limit	Same as any other Illness	Deductible and Comsurance
Barium Enema, and other tests as		
determined under ACA Preventive Services		
determined under ACA Preventive Services - Preventive Screenings - Diagnostic Screenings	Plan Pays 100% Same as any other Illness	Deductible and Coinsurance Deductible and Coinsurance

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Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Benefits for office visit include the office visit, medi	ication checks, psychological therapy and/	or Substance Use Disorder counseling.
Office Services	Deductible and Coinsurance	Deductible and Coinsurance
The following office Services are available when produring the office visit .	ovided in the office; X-rays, laboratory tests	s, supplies and/or drugs administered
All Other Outpatient Items and Services	Deductible and Coinsurance	Deductible and Coinsurance
Other Services provided in the office but NOT included	in the office visit or office Services be	enefit listed above include, but are not
limited to; psychological evaluations, assessments, tes	sting, physical therapy, occupational therap	oy, speech therapy or any other covered
Mental Health and/or Substance Use Disorder Service		
Telehealth/Virtual Care Services	Deductible and Coinsurance	Not Covered
Emergency Room Services		
 Facility 	Deductible and Coinsurance	In-network level of benefits
 Professional Services 	Deductible and Coinsurance	In-network level of benefits
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
For additional resources and support visit Nebra	skaBlue.com/MentalHealth	
Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care)		
 Ground Ambulance 	Deductible and Coinsurance	In-network level of benefits
Air Ambulance	Deductible and Coinsurance	In-network level of benefits
Autism Spectrum Disorder		
Testing and Diagnosis	Same as Mental Health	Same as Mental Health
 Treatment 	Same as Mental Health	Same as Mental Health
Biofeedback		
 Medical 	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health	Same as Mental Health	Same as Mental Health
Dermatological Services	Same as any other Illness	Same as any other Illness
Diabetic Services	,	,
Services include education, self-management	Same as any other Illness	Deductible and Coinsurance
training, podiatric appliances, and equipment.		
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
NOTE: Benefits for specific prescription drugs are covered to the spec		
an emergency room. A list of these specific drugs is av department.	vailable at <u>NebraskaBlue.com/Pharmacy</u> or	by contacting the Member Services
Durable Medical Equipment and Supplies		
(including Prosthetics)	Deductible and Coinsurance	Deductible and Coinsurance
(rental or purchase, whichever is least costly, rental		
shall not exceed the cost of purchasing)		
Hearing Services	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids Cachlery Implement		
Cochlear Implants	Deductible and Coinsurance	Deductible and Coinsurance
 Hearing Aids and related Services (up to age 19, limited to \$3,000 every 48 months) 	Deductible and Coinsurance	Deductible and Coinsurance

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Other Covered Services – Illness or Injury	In-network cProvider	Out-of-network Provider
Home Health Care Services		
Home Health Aide (limited to 60 days per	Deductible and Coinsurance	Deductible and Coinsurance
Calendar Year)		
 Home Infusion Therapy 	Deductible and Coinsurance	Deductible and Coinsurance
 Respiratory Care (limited to 60 days per Calendar Year) 	Deductible and Coinsurance	Deductible and Coinsurance
 Skilled Nursing Care (limited to 8 hours per day) 	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
 Diagnostic 	Deductible and Coinsurance	In-network level of benefits
 Preventive 	Same as Preventive Services In- network level of benefits	Same as Preventive Services In-network level of benefits
Infertility		
 Services to Diagnose 	Same as any other Illness	Deductible and Coinsurance
 Treatment to Promote Fertility 	Not Covered	Not Covered
Nicotine AddictionMedical Services and Therapy	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services
 Nicotine Addiction Classes & Alternative Therapy, such as Acupuncture 	Not Covered	Not Covered
ObesityNon-Surgical Treatment	Not Covered	Not Covered
Surgical Treatment	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	Deductible and Coinsurance
Organ and Tissue Transplantation	Same as any other Illness	Deductible and Coinsurance
Ostomy Supplies	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
Pregnancy, Maternity and Newborn Care Pregnancy and Maternity (payment for prenatal and postnatal care is included in the payment for the delivery) Newborn Care (paywharra are accounted to the payment)	Deductible and Coinsurance	Deductible and Coinsurance
 Newborn Care (newborns are covered at birth, subject to the plans enrollment provisions) 	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: The plan pays 100% for the initial postpartum	depression screening up to one year follow	ving a Pregnancy or childbirth

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance
 Rehabilitation Services Cardiac Rehabilitation (limited to 18 sessions per diagnosis) Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year.) 	Deductible and Coinsurance	Deductible and Coinsurance
(Lung, Heart-Lung transplants and Lung Volume Reduction are limited to 18 sessions following referral and prior to surgery and 18 sessions after surgery, within six months of discharge from Hospital.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Same as any other Illness	Deductible and Coinsurance
 Therapy & Manipulations Physical, Occupational or Speech Therapy Services, Chiropractic or Osteopathic Physiotherapy (combined limit of 60 sessions per Calendar Year for both rehabilitative and Habilitative Services). Chiropractic or Osteopathic Manipulative 	Deductible and Coinsurance	Deductible and Coinsurance
Treatments or Adjustments (combined limit of 20 sessions per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Treatment limits stated for physical therapy, occup provided for Mental Health and/or Substance Use Disorde Year limit.		
Vision Services • Eyeglasses or Contact Lenses (only covered if required because of a change in prescription due to intraocular surgery or ocular Injury, must be within 12 months of surgery or Injury)	Deductible and Coinsurance	Deductible and Coinsurance
 Eye Exam Diagnostic (to diagnose an Illness) Preventive (routine exam including 	See Physician Office Services	See Physician Office Services
refraction) limited to one exam per Calendar Year	Not Covered	Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	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 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.

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