Schedule of Benefits Summary

Group Name: Triage, LLC

Effective Date: January 01, 2023

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 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.		
In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit www.NebraskaBlue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	 $7,050 $14,100	 $14,100 $28,200
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays	 0%	 0%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan) • Individual • Family (Embedded*)	 $7,050 $14,100	 $14,100 $28,200
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.		
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.) 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 Illness and/or Substance Dependence and Abuse.		
*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.		

Copayment(s) (copay(s)) apply to:

- Prescription Drugs

The Copay amount varies by the type of Covered Service. Refer to the appropriate category for benefit information.

Out-of-pocket Limit includes:

- Deductible
- Coinsurance

The Deductible must be met each Calendar Year before Copays and Coinsurance are applicable.

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office		
• Primary Care Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
• Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Deductible and Coinsurance	Deductible and Coinsurance
• Allergy Injections and Serum	Deductible and Coinsurance	Deductible and Coinsurance
• Other Injections	Deductible and Coinsurance	Deductible and Coinsurance

Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician.

Specialist Physician is a physician who is not a Primary Care Physician.

Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.

Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include: Allergy Injections & Serum; Other Injections; Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.

Telehealth Services	Deductible and Coinsurance	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 Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services 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
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance

NOTE: Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See www.NebraskaBlue.com for a list of Covered Services and designated hospitals.

Preventive Services	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%	Deductible and Coinsurance
• ACA required covered preventive services (outside of limits)	Plan Pays 100%	Deductible and Coinsurance
• Other covered preventive services not required by ACA, such as:		
- Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; metabolic panel; prostate cancer screening (PSA) and hearing exams	Plan Pays 100%	Deductible and Coinsurance
- All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services	Same as an illness	Same as an illness
Immunizations		
• 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
Colorectal Cancer Screenings (starting at age 45)		
• Colonoscopy Screening		
- Diagnostic or Preventive Screening (one every five years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Same as any other illness	Deductible and Coinsurance
• Sigmoidoscopy/Proctoscopy Screening		
- Preventive Screening (one every five years)	Play Pays 100%	Deductible and Coinsurance
- Screenings outside the age or frequency limit	Same as any other illness	Deductible and Coinsurance
• Barium enema, Fecal occult blood tests, FIT DNA, CT of the Colon and other tests as determined under ACA Preventive Services		
- Preventive Screenings	Play Pays 100%	Deductible and Coinsurance
- Diagnostic Screenings	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.		
Mental Illness and/or Substance Dependence and Abuse Covered Services	**In-network Provider**	**Out-of-network Provider**
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth Services	Deductible and Coinsurance	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits

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 • Air Ambulance	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Autism Spectrum Disorder	Same as mental illness	Same as mental illness
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids and Cochlear Implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other outpatient settings) (**NOTE:** Benefits for specific prescription drugs and covered services administered in an outpatient setting, other than a hospital emergency room, are not payable under Medical. These drugs are only payable under the Prescription Drug plan. A list of these drugs and covered services is available on the website www.NebraskaBlue.com or by contacting the Member Services Department.)	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
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids (up to age 19 limited to $3,000 every 48 months)	Same as any other illness	Same as any other illness
Home Health Aide, Skilled Nursing and Respiratory Care • Home Health Aide (limited to 60 days per Calendar Year) • Skilled Nursing Care (limited to 8 hours per day) • Respiratory Care (limited to 60 days per Calendar Year)	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	 Deductible and Coinsurance Same as Preventive Services In-network level of benefits	 In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	 Same as any other illness Not Covered	 Same as any other illness Not Covered
Nicotine Addiction • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	 Same as Substance Dependence and Abuse Not Covered	 Same as Substance Dependence and Abuse Not Covered
Obesity • Non-surgical treatment • Surgical Treatment	 Not Covered 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).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, 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)	Deductible and Coinsurance	Deductible and Coinsurance
• Newborn care	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.		
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	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)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
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	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year for both rehabilitative and habilitative services) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year)	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction)	See Physician Office Services Not Covered	See Physician Office Services Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs	In-network Provider	Out-of-network Provider
Retail – per 30-day supply		
• Generic drugs (including non-preferred contraceptives)	Deductible and Coinsurance	Deductible then 50% Coinsurance
• Preferred Brand Name Drugs	Deductible and Coinsurance	Deductible then 50% Coinsurance
• Non-preferred Brand Name Drugs	Deductible and Coinsurance	Deductible then 50% Coinsurance
Home Delivery – per 90-day supply		
• Generic drugs (including non-preferred contraceptives)	Deductible and Coinsurance	Not Covered
• Preferred Brand Name Drugs	Deductible and Coinsurance	Not Covered
• Non-preferred Brand Name Drugs	Deductible and Coinsurance	Not Covered
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after one fill)	Same as retail	Not Covered
Contraceptives		
• Preferred		
- Generic	Plan Pays 100%	50% Coinsurance
- Brand Name	Plan Pays 100%	50% Coinsurance
• Non-preferred		
- Generic	Same as any other Generic Drugs	
- Brand Name	Same as any other Non-preferred Brand Name	
Diabetic Insulin		
• Preferred		
- Generic	Plan Pays 100%	50% Coinsurance
- Brand Name	Plan Pays 100%	50% Coinsurance
• Non-preferred		
- Generic	Same as any other Generic Drugs	
- Brand Name	Same as any other Non-preferred Brand Name	
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	50% Coinsurance
Obesity FDA approved prescription drugs	Not Covered	Not Covered
This plan uses a prescription drug list (PDL). The PDL for this plan is 20, and the Pharmacy Network is C. You can find this prescription drug list and network listing on www.NebraskaBlue.com. Or you may contact Member Services at the phone number on the back of your I.D. card.		

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.