

Schedule of Benefits Summary

Group Name: Pando LLC

Effective Date: January 01, 2026

Payment for Services	In-network Provider	Out-of-network Provider
<p>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.</p>		
<p>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.</p>		
<p>Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$5,000 \$10,000</p>	<p>\$10,000 \$20,000</p>
<p>Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> Covered Person Pays Plan Pays 	<p>0% 100%</p>	<p>20% 80%</p>
<p>Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$6,350 \$12,700</p>	<p>\$14,000 \$28,000</p>
<p>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.</p>		
<p>*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.</p>		
<p>Copayment(s) (Coplay(s)) apply to:</p> <ul style="list-style-type: none"> Physician Office Emergency Room Services Telehealth/Virtual Care Prescription Drugs Urgent Care Facility <p>The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.</p>		
<p>Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits. For additional information regarding Preauthorization procedures visit NebraskaBlue.com/PreAuth.</p>		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Primary Care Physician Office Visit	\$35 Copay	Deductible and Coinsurance
Specialist Physician Office Visit	\$50 Copay	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.		
Physician Office Services	Applicable Office Visit Copay	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, allergy testing, injections and serums, 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. <i>(Refer to the appropriate categories below and your benefit book for additional information.)</i>		
Telehealth/Virtual Care Services		
<ul style="list-style-type: none"> • Medical • Mental Health 	\$10 Copay See Mental Health and/or Substance Use Disorder Services	Not Covered Not Covered
Convenient Care/Retail Clinics/Quick Care	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services (a single Copay applies to each urgent care visit)	\$75 Copay	Deductible and Coinsurance
Emergency Room Services		
<ul style="list-style-type: none"> • Facility • Professional Services (Copay waived when admitted to the Hospital within 24 hours for the same diagnosis)	\$250 Copay then Coinsurance Coinsurance	In-network level of benefits 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
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
Orthopedic Specialty Hospital or Facility Services		
	Deductible and Coinsurance	Deductible and Coinsurance
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.		

Preventive Services	In-network Provider	Out-of-network Provider
<p>Preventive Services</p> <ul style="list-style-type: none"> Affordable Care Act (ACA) required Preventive Services (may be subject to limits that include but are not limited to age, gender, and frequency) ACA-required covered Preventive Services (outside of limits) Other covered Preventive Services not required by ACA <p>For additional information visit NebraskaBlue.com/PreventiveCare</p>	<p>Plan Pays 100%</p> <p>Same as any other Illness</p> <p>Same as any other Illness</p>	<p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p>
<p>Immunizations</p> <ul style="list-style-type: none"> Pediatric (up to age 7) Age 7 and older Related to an Illness 	<p>Plan Pays 100%</p> <p>Plan Pays 100%</p> <p>Same as any other Illness</p>	<p>Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Same as any other Illness</p>
<p>Colorectal Cancer Screenings (starting at age 45)</p> <ul style="list-style-type: none"> Colonoscopy Screening <ul style="list-style-type: none"> Diagnostic or Preventive Screening (one every five years) Screenings outside the age or frequency limit Sigmoidoscopy/Proctoscopy Screening and CT of the Colon <ul style="list-style-type: none"> Preventive Screening (one every five years) Screenings outside the age or frequency limit FIT DNA <ul style="list-style-type: none"> Preventive Screening (one every three years) Screenings outside the age or frequency limit Fecal Occult Blood Test <ul style="list-style-type: none"> Preventive Screening (one per year) Screenings outside the age or frequency limit Barium Enema, and other tests as determined under ACA Preventive Services <ul style="list-style-type: none"> Preventive Screenings Diagnostic Screenings 	<p>Plan Pays 100%</p> <p>Same as any other Illness</p> <p>Plan Pays 100%</p> <p>Same as any other Illness</p> <p>Plan Pays 100%</p> <p>Same as any other Illness</p> <p>Plan Pays 100%</p> <p>Same as any other Illness</p> <p>Plan Pays 100%</p> <p>Same as any other Illness</p>	<p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p>
<p>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.</p>		

Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Office Visit Benefits for office visit include the office visit , medication checks, psychological therapy and/or Substance Use Disorder counseling.	Plan Pays 100%	Deductible and Coinsurance
Office Services The following office Services are available when provided in the office; X-rays, laboratory tests, supplies and/or drugs administered during the office visit .	Plan Pays 100%	Deductible and Coinsurance
All Other Outpatient Items and Services Other Services provided in the office but NOT included in the office visit or office Services benefit listed above include, but are not limited to; psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered Mental Health and/or Substance Use Disorder Services.	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth/Virtual Care Services	Plan Pays 100%	Not Covered
Emergency Room Services <ul style="list-style-type: none"> Facility Professional Services (Copay waived when admitted to the Hospital within 24 hours for the same diagnosis)	\$250 Copay then Coinsurance Coinsurance	In-network level of benefits In-network level of benefits
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
For additional resources and support visit NebraskaBlue.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) <ul style="list-style-type: none"> Ground Ambulance Air Ambulance 	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Autism Spectrum Disorder <ul style="list-style-type: none"> Testing and Diagnosis Treatment 	Same as Mental Health Same as Mental Health	Same as Mental Health Same as Mental Health
Biofeedback <ul style="list-style-type: none"> Medical Mental Health 	Deductible and Coinsurance Same as Mental Health	Deductible and Coinsurance Same as Mental Health
Dermatological Services	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	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings) NOTE: Benefits for specific prescription drugs are covered under the prescription drug plan and not payable under medical, other than in an emergency room. A list of these specific drugs is available at NebraskaBlue.com/Pharmacy 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
Hearing Services <ul style="list-style-type: none"> Bone Anchored Hearing Aids Cochlear Implants 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	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services <ul style="list-style-type: none"> Home Health Aide (limited to 60 days per Calendar Year) Home Infusion Therapy Respiratory Care (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day) 	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory <ul style="list-style-type: none"> Diagnostic Preventive 	Plan Pays 100% Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility <ul style="list-style-type: none"> Services to Diagnose Treatment to Promote Fertility 	Same as any other Illness Not Covered	Deductible and Coinsurance Not Covered
Nicotine Addiction <ul style="list-style-type: none"> Medical Services and Therapy Nicotine Addiction Classes & Alternative Therapy, such as Acupuncture 	Same as Substance Use Disorder Services Not Covered	Same as Substance Use Disorder Services Not Covered
Obesity <ul style="list-style-type: none"> 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)	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 <ul style="list-style-type: none"> Pregnancy and Maternity (payment for prenatal and postnatal care is included in the payment for the delivery) Newborn Care (newborns are covered at birth, subject to the plans enrollment provisions) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
NOTE: The plan pays 100% for the initial postpartum depression screening up to one year following a Pregnancy or childbirth.		

Prescription Drugs	In-network Provider	Out-of-network Provider
Retail – per 30-day supply <ul style="list-style-type: none"> Preferred Generic Drugs Non-Preferred Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs 	\$10 Copay \$10 Copay \$30 Copay \$50 Copay	50% Coinsurance 50% Coinsurance 50% Coinsurance 50% Coinsurance
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy.		
Home Delivery – per 90-day supply <ul style="list-style-type: none"> Preferred Generic Drugs Non-Preferred Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs 	\$30 Copay \$30 Copay \$90 Copay \$150 Copay	Not Covered Not Covered Not Covered Not Covered
Specialty Drugs (Specialty Drugs must be purchased through a designated Specialty Pharmacy) <ul style="list-style-type: none"> Preferred Specialty Drugs Non-Preferred Specialty Drugs 	\$100 Copay \$100 Copay	Not Covered Not Covered
Contraceptive Drugs <ul style="list-style-type: none"> Contraceptive Drugs and Methods in accordance with Federal Guidelines All other Contraceptive Drugs and Methods 	Plan Pays 100% Same as any other Generic or Brand Name Drugs	50% Coinsurance 50% Coinsurance
For additional information see Women’s Services listed on NebraskaBlue.com/PreventiveCare		
Diabetic Insulin <ul style="list-style-type: none"> Preferred Generic Drugs Non-Preferred Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs 	Plan Pays 100% Same as any other Generic Drugs Plan Pays 100% Same as any other Non-Preferred Brand Name Drugs	50% Coinsurance 50% Coinsurance 50% Coinsurance 50% Coinsurance
<p style="text-align: center;">This plan utilizes the Broad Network C and NetResults Performance Prescription Drug List (PDL). You can find this PDL and network listing on NebraskaBlue.com/Pharmacy or you may contact Member Services at the phone number on the back of your I.D. card.</p>		

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.