Schedule of Benefits Summary

Group Name: Population Science Management | 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. **There is no Out-of-network coverage under this Plan.**		
In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit mygigcare.net. 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. Please refer to your benefit book for additional information.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
• Individual	$5,000	N/A
• Family (Embedded*)	$10,000	N/A
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
• Covered Person Pays	30%	N/A
• Plan Pays	70%	N/A
Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments)		
• Individual	$7,350	N/A
• Family (Embedded*)	$14,700	N/A
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: • Physician Office • Telehealth/Virtual Care • Urgent Care Facility • Cardiac and Pulmonary Rehabilitation • Physical, Occupational Speech Therapy • Manipulations and Adjustments • Prescription Drugs 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.		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Primary Care Physician Office Visit	$25 Copay	Not Covered
Specialist Physician Office Visit	$40 Copay	Not Covered
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	Not Covered
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. *(Refer to the appropriate categories below and your benefit book for additional information.)*		
Telehealth/Virtual Care Services • Medical • Mental Health	Same as In Person Visit 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	Not Covered
Urgent Care Facility Services (a single Copay applies to each urgent care visit)	$75 Copay	Not Covered
Emergency Room Services • 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 include but are not limited to surgery, laboratory and radiology, observation stays, and other Services provided on an Outpatient basis.	Deductible and Coinsurance	Not Covered
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	Not Covered
NOTE: Combined Medical and Mental Health Limit of 30-days per Covered Person per Calendar Year for Inpatient Stays.		

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%	Not Covered
• ACA-required covered Preventive Services (outside of limits)	Same as any other Illness	Not Covered
• Other covered Preventive Services not required by ACA	Same as any other Illness	Not Covered
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Not Covered
• Age 7 and older	Plan Pays 100%	Not Covered
• Related to an Illness	Same as any other Illness	Not Covered
Colorectal Cancer Screenings (starting at age 45)		
• Colonoscopy Screening		
- Diagnostic or Preventive Screening (one every five years)	Plan Pays 100%	Not Covered
- Screenings outside the age or frequency limit	Same as any other Illness	Not Covered
• Sigmoidoscopy/Proctoscopy Screening and CT of the Colon		
- Preventive Screening (one every five years)	Plan Pays 100%	Not Covered
- Screenings outside the age or frequency limit	Same as any other Illness	Not Covered
• FIT DNA		
- Preventive Screening (one every three years)	Plan Pays 100%	Not Covered
- Screenings outside the age or frequency limit	Same as any other Illness	Not Covered
• Fecal Occult Blood Test		
- Preventive Screening (one per year)	Plan Pays 100%	Not Covered
- Screenings outside the age or frequency limit	Same as any other Illness	Not Covered
• Barium Enema, and other tests as determined under ACA Preventive Services		
- Preventive Screenings	Plan Pays 100%	Not Covered
- Diagnostic Screenings	Same as any other Illness	Not Covered
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.		

Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Office Visit	$25 Copay	Not Covered
Benefits for **office visit** include the **office visit**, medication checks, psychological therapy and/or Substance Use Disorder counseling.		
Office Services	Applicable Office Visit Copay	Not Covered
The following **office Services** are available when provided in the office; X-rays, laboratory tests, supplies and/or drugs administered during the **office visit**.		
All Other Outpatient Items and Services	Deductible and Coinsurance	Not Covered
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.		
Telehealth/Virtual Care Services	Same as In Person Visit	Not Covered
Emergency Room Services • Facility • Professional Services	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Inpatient Services	Deductible and Coinsurance	Not Covered
NOTE: Combined Medical and Mental Health Limit of 30-days per Covered Person per Calendar Year for Inpatient Stays.		

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	Not Covered
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 • Testing and Diagnosis • Treatment	 Same as Mental Health Same as Mental Health	 Not Covered Not Covered
Biofeedback • Medical • Mental Health	 Deductible and Coinsurance Same as Mental Health	 Not Covered Not Covered
Dermatological Services	Same as any other Illness	Not Covered
Diabetic Services Services include education, self-management training, podiatric appliances, and equipment.	Same as any other Illness	Not Covered
Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)	Same as any other Illness	Not Covered
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 by contacting the Member Services department.		
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing) Prosthetics and Orthotic Devices limited to $6,500 per member per year	Deductible and Coinsurance	Not Covered
Hearing Services • 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	 Not Covered Not Covered Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services • Home Health Aide and Respiratory Care (combined limit up to 60 days per Calendar Year) • Home Infusion Therapy • Skilled Nursing Care (limited to 8 hours per day, limited to 60 days per Calendar Year)	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Not Covered Not Covered Not Covered
Hospice Services	Deductible and Coinsurance	Not Covered
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services	Not Covered Not Covered
Infertility • Services to Diagnose • Treatment to Promote Fertility	Same as any other Illness Not Covered	Not Covered Not Covered
Nicotine Addiction • Medical Services and Therapy • Nicotine Addiction Classes & Alternative Therapy, such as Acupuncture	Same as Substance Use Disorder Services Not Covered	Not Covered 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)	Same as any other Illness	Not Covered
Organ and Tissue Transplantation	Same as any other Illness	Not Covered
Ostomy Supplies	Deductible and Coinsurance	Not Covered
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	Not Covered
Pregnancy, Maternity and Newborn Care • 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	Not Covered Not Covered
NOTE: Dependent Daughter Maternity is Not Covered. **NOTE:** The plan pays 100% for the initial postpartum depression screening up to one year following a Pregnancy or childbirth.		

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Not Covered
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Not Covered
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Not Covered
Rehabilitation Services • Cardiac Rehabilitation (limited to 15 sessions per diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 15 sessions per diagnosis, not to exceed 15 sessions per Calendar Year.) (Lung, Heart-Lung transplants and Lung Volume Reduction are limited to 15 sessions following referral and prior to surgery and 15 sessions after surgery, within six months of discharge from Hospital.)	$40 Copay $40 Copay	Not Covered Not Covered
Renal Dialysis	Deductible and Coinsurance	Not Covered
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Not Covered
Sleep Studies	Deductible and Coinsurance	Not Covered
Temporomandibular and Craniomandibular Joint Disorder	Same as any other Illness	Not Covered
Therapy & Manipulations • Physical and Occupational Therapy Services, Chiropractic or Osteopathic Physiotherapy (combined limit of 15 sessions per Calendar Year for both rehabilitative and Habilitative Services). • Speech therapy Services (limited to 15 sessions per Calendar Year) • Chiropractic or Osteopathic Manipulative Treatments or Adjustments (combined limit of 15 sessions per Calendar Year)	$40 Copay $40 Copay $40 Copay	Not Covered Not Covered Not Covered
NOTE: Treatment limits stated for physical therapy, occupational therapy and speech therapy Services are not applicable to treatment provided for Mental Health and/or Substance Use Disorder Services. Evaluations are covered but do not apply to the combined Calendar 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) • Eye Exam - Diagnostic (to diagnose an Illness) - Preventive (routine exam including refraction) limited to one exam per Calendar Year	Deductible and Coinsurance See Physician Office Services Plan Pays 100%	Not Covered Not Covered Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Not Covered

Prescription Drugs	In-network Provider	Out-of-network Provider
Retail – per 30-day supply		
• Generic Drugs	25%, $10 Minimum/$450 Maximum	Not Covered
• Preferred Brand Name Drugs	25%, $105 Minimum/$450 Maximum	Not Covered
• Non-Preferred Brand Name Drugs	Not Covered	Not Covered
Home Delivery – per 90-day supply		
• Generic Drugs	25%, $30 Minimum/$1,350 Maximum	Not Covered
• Preferred Brand Name Drugs	25%, $315 Minimum/$1,350 Maximum	Not Covered
• Non-Preferred Brand Name Drugs	Not Covered	Not Covered
Specialty Drugs (Specialty Drugs must be purchased through a designated Specialty Pharmacy)		
• Preferred Specialty Drugs	Not Covered	Not Covered
• Non-Preferred Specialty Drugs	Not Covered	Not Covered
Contraceptive Drugs		
• Contraceptive Drugs and Methods in accordance with Federal Guidelines	Plan Pays 100%	Not Covered
• All other Contraceptive Drugs and Methods	Same as any other Generic or Brand Name Drugs	Not Covered
Diabetic Insulin		
• Generic Drugs	$10 Copay	Not Covered
• Preferred Brand Name Drugs	$35 Copay	Not Covered
• Non-Preferred Brand Name Drugs	Not Covered	Not Covered
This plan utilizes the Broad Network C and BlueChoice Meds Prescription Drug List (PDL). You can find this PDL and network listing on MyPrime.com or you may contact Member Services at the phone number on the back of your I.D. card.		