Schedule of Benefits Summary

Group Name: Population Science Management, 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 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 • Family (Embedded*)	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays • Plan Pays	 30% 70%	 50% 50%
Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments) • Individual • Family (Embedded*)	 $8,500 $17,000	 $20,000 $40,000
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: • 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	Deductible and Coinsurance
Specialist Physician Office Visit	$40 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. *(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	Deductible and Coinsurance Deductible and Coinsurance
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)	$60 Copay	Deductible and Coinsurance
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	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

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)	Same as any other Illness	Deductible and Coinsurance
• Other covered Preventive Services not required by ACA	Same as any other Illness	Deductible and Coinsurance
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Deductible and Coinsurance
• Age 7 and older	Plan Pays 100%	Deductible and Coinsurance
• Related to an Illness	Same as any other Illness	Deductible and Coinsurance
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 and CT of the Colon		
- 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
• 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 frequency limit	Same as any other Illness	Deductible and Coinsurance
• Barium Enema, and other tests as determined under ACA Preventive Services		
- Preventive Screenings	Plan 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. 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	Deductible and Coinsurance
Benefits for **office visit** include the **office visit**, medication checks, psychological therapy and/or Substance Use Disorder counseling.		
Office Services	Applicable Office Visit Copay	Deductible and Coinsurance
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	Deductible and Coinsurance
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	Deductible and Coinsurance
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	Deductible and Coinsurance
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 • Testing and Diagnosis • Treatment	 Same as Mental Health Same as Mental Health	 Same as Mental Health Same as Mental Health
Biofeedback • 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)	Same as any other Illness	Same as any other Illness
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	Deductible and Coinsurance
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	 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		
• Home Health Aide and Respiratory Care (combined limit up to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
• Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
• Skilled Nursing Care (limited to 8 hours per day, limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic	Deductible and Coinsurance	Deductible and Coinsurance
• Preventive	Same as Preventive Services	Same as Preventive Services
Infertility		
• Services to Diagnose	Same as any other Illness	Deductible and Coinsurance
• Treatment to Promote Fertility	Not Covered	Not Covered
Nicotine Addiction		
• Medical 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
Obesity		
• Non-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)	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: 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	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 20 sessions per diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 20 sessions per diagnosis, not to exceed 20 sessions per Calendar Year.) (Lung, Heart-Lung transplants and Lung Volume Reduction are limited to 20 sessions following referral and prior to surgery and 20 sessions after surgery, within six months of discharge from Hospital.)	$40 Copay $40 Copay	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 and Occupational Therapy Services, Chiropractic or Osteopathic Physiotherapy (combined limit of 20 sessions per Calendar Year for both rehabilitative and Habilitative Services). • Speech therapy Services (limited to 20 sessions per Calendar Year) • Chiropractic or Osteopathic Manipulative Treatments or Adjustments (combined limit of 20 sessions per Calendar Year)	$40 Copay $40 Copay $40 Copay	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
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%	Deductible and Coinsurance See Physician Office Services Deductible and Coinsurance
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	25%, $10 Minimum/$450 Maximum	Not Covered
• Preferred Brand Name Drugs	25%, $45 Minimum/$450 Maximum	Not Covered
• Non-Preferred Brand Name Drugs	25%, $105 Minimum/$450 Maximum	Not Covered
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy.		
Home Delivery – per 90-day supply		
• Generic Drugs	25%, $30 Minimum/$1,350 Maximum	Not Covered
• Preferred Brand Name Drugs	25%, $135 Minimum/$1,350 Maximum	Not Covered
• Non-Preferred Brand Name Drugs	25%, $315 Minimum/$1,350 Maximum	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	$85 Copay	Not Covered
This plan utilizes the Broad Network C and NetResults Performance 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.		