Schedule of Benefits Summary

Group Name: Population Science Management of Nebraska

Effective Date: May 1, 2024

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. 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.		
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	 20% 80%	 40% 60%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays) • Individual • Family (Embedded*)	 $7,350 $14,700	 $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.) 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 Health and/or Substance Use Disorders. 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 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: • Physician Office • Cardiac Rehabilitation • Physical, Occupational and Speech Therapy Services • Telehealth/Virtual Care • Prescription Drugs • Urgent Care Facility • Manipulations and Adjustments 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
Physician Office Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Physician Office Services provided in the office (with or without an office visit)	 $25 Copay $40 Copay Applicable office visit copay	 Deductible and Coinsurance 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), consultations and medication checks. ***Physician Office Services*** include but are not limited to: office visits; X-ray; laboratory and pathology services; Allergy Testing, Injections and Serums; Supplies and/or Drugs administered during the office visit; Hearing exams or Eye exams due to Illness or Injury excluding refractions. ***Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:*** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.		
Telehealth/Virtual Care Services • Medical • Mental Health	 $25 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)	$60 Copay	Deductible and Coinsurance
Emergency Room 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

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	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
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	$25 Copay	Deductible and Coinsurance
• Telehealth/Virtual Care Services	$25 Copay	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Office Services include office visits; medication checks; psychological therapy and/or substance use disorder counseling; x-rays; laboratory tests; supplies and/or drugs administered during the office visit. ***Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items & Services.*** This includes but is 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.		
Emergency Room 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	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 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 a hospital 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)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Services		
• Bone Anchored Hearing Aids	Deductible and Coinsurance	Deductible and Coinsurance
• Cochlear Implants	Deductible and Coinsurance	Deductible and Coinsurance
• Hearing Aids (up to age 19, limited to $3,000 every 48 months.)	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) • 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	Deductible and Coinsurance 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	Deductible and Coinsurance Not Covered
Nicotine Addiction • 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 • 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 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) • Newborn care (Newborns are covered at birth, subject to the plan's 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.		

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. 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.)	 $40 Copay Deductible and Coinsurance	 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 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	 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 or Substance Use Disorders. Evaluations are covered and 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 as a result of intraocular surgery or ocular injury) must be within 12 months of surgery or injury • Vision 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 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		
• Preferred Generic Drugs	$10 Copay	Not Covered
• Preferred Brand Name Drugs	$45 Copay	Not Covered
• Non-preferred Brand Name Drugs	$85 Copay	Not Covered
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy.		
Home Delivery – per 90-day supply		
• Preferred Generic Drugs	$30 Copay	Not Covered
• Preferred Brand Name Drugs	$135 Copay	Not Covered
• Non-preferred Brand Name Drugs	$255 Copay	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		
• Preferred Generic Drugs	Plan Pays 100%	Not Covered
• Preferred Brand Name Drugs	Plan Pays 100%	Not Covered
• Non-Preferred Brand Name Drugs	Same as any other Non-Preferred Brand Name Drugs	Not Covered
Diabetic Insulin		
• Preferred 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 Prescription Drug List (PDL) 40. You can find this prescription drug list and network listing on MyPrime.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.