

Effective Date: January 1, 2026

Schedule of Benefits Summary

Group Name: Population Science Management, LLC.

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 <u>mygigcare.net</u>. 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	\$10,000
 Family (Embedded*) 	\$10,000	\$20,000
Coinsurance		
(the percentage amount the Covered Person must pay		
for most Covered Services after the Deductible has		
been met)		
Covered Person Pays	30%	50%
Plan Pays	70%	50%
Out-of-pocket Limit		
(includes Deductible, Coinsurance and Copayments)		
Individual	\$8,500	\$20,000
 Family (Embedded*) 	\$17,000	\$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:

This plan has no medical or prescription drug copays

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	Deductible and Coinsurance	Deductible and Coinsurance
Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Benefits for Primary Care Physician or Specialis diagnose Pregnancy), consultations and medication		visit (including the initial visit to
Physician Office Services	Deductible and Coinsurance	Deductible and Coinsurance
The following Physician Office Services are avain office, with or without an office visit; X-rays, labour drugs administered during the office visit, hearing Other Services provided in the office but NOT included in the office but and	ratory and pathology Services, allergy testing, exams or eye exams (excluding refractions) du	injections and serums, supplies and/o ue to Illness or Injury.
above, include but are not limited to; Preventive S Advanced Diagnostic Imaging (CT, MRI, MRA, N Equipment, Pregnancy, Maternity and Newborn Manipulations and Surgery and Anesthesia. (<i>Refe</i>	ervices, Mental Health and/or Substance /IRS, PET and SPECT scans and other Nuclear n Care, Radiation Therapy and Chemother	Use Disorder Services, Biofeedbac Medicine), Durable Medical apy, Sleep Studies, Therapy and
Telehealth/Virtual Care Services		
 Medical 	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health	See Mental Health and/or Substance Use Disorder Services	Deductible and Coinsurance
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 Room Services		
 Facility 	Deductible and Coinsurance	In-network level of benefits
 Professional Services 	Deductible and Coinsurance	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

Services and other ancillary Services provided on an

Inpatient basis.

reventive Services	In-network Provider	Out-of-network Provider
reventive Services		
Affordable Care Act (ACA) required		
Preventive Services (may be subject to	Plan Pays 100%	Deductible and Coinsurance
limits that include but are not limited to	1 1411 1 475 1 55 75	Boddelible and comediance
age, gender, and frequency)		
ACA-required covered Preventive Services	Same as any other Illness	Deductible and Coinsurance
(outside of limits)Other covered Preventive Services not		
required by ACA	Same as any other Illness	Deductible and Coinsurance
munizations		
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
lorectal Cancer Screenings (starting at age 45)	,	
 Colonoscopy Screening 		
- Diagnostic or Preventive Screening	Plan Pays 100%	Deductible and Coinsurance
(one every five years)	Tidii Tays 100 /0	Deductible and comsulation
- Screenings outside the age or	Same as any other Illness	Deductible and Coinsurance
frequency limit Sigmoidoscopy/Proctoscopy Screening and		
CT of the Colon		
- Preventive Screening (one every five	D. D. 1000/	5
years)	Plan Pays 100%	Deductible and Coinsurance
- Screenings outside the age or	Same as any other Illness	Deductible and Coinsurance
frequency limit	Jame as any other filless	Deductible and Comsulance
• FIT DNA		
- Preventive Screening (one every three	Plan Pays 100%	Deductible and Coinsurance
years) - 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	Same as any other Illness	Deductible and Coinsurance
frequency limit	Junio do dily Julio Illinoss	Boddenbie did Comsulation
Barium Enema, and other tests as		
determined under ACA Preventive Services	Dian Davis 1000/	Doductible and Cainavira
Preventive ScreeningsDiagnostic Screenings	Plan Pays 100% Same as any other Illness	Deductible and Coinsurance Deductible and Coinsurance
- Diagnostic screenings	Same as any other inness	Deductible and Comsulative

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	Deductible and Coinsurance	Deductible and Coinsurance
Benefits for office visit include the office visit , medi	cation checks, psychological therapy and/c	or Substance Use Disorder counseling.
Office Services	Deductible and Coinsurance	Deductible and Coinsurance
The following office Services are available when produring the office visit .	ovided in the office; X-rays, laboratory tests	, supplies and/or drugs administered
All Other Outpatient Items and Services	Deductible and Coinsurance	Deductible and Coinsurance
Other Services provided in the office but NOT included limited to; psychological evaluations, assessments, tes Mental Health and/or Substance Use Disorder Service	sting, physical therapy, occupational therap	
Telehealth/Virtual Care Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room Services		
 Facility 	Deductible and Coinsurance	In-network level of benefits
 Professional Services 	Deductible and Coinsurance	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	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	Same as any other Illness	Deductible and Coinsurance
training, podiatric appliances, and equipment.		
Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient	Same as any other Illness	Same as any other Illness
settings) NOTE: Benefits for specific prescription drugs are covered to the specific prescription drugs are covered t		
an emergency room. A list of these specific drugs is av	vallable 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	Deductible and Coinsurance	Deductible and Coinsurance
and Orthotic Devices limited to \$6,500 per member		
per year		
Hearing Services	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids Cook London London		
Cochlear Implants Usering Aids and related Services (up to	Deductible and Coinsurance	Deductible and Coinsurance
 Hearing Aids and related Services (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	Deductible and Coinsurance	Deductible and Coinsurance
Year)		
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
 Skilled Nursing Care (limited to 8 hours 		
per day, limited to 60 days per Calendar	Deductible and Coinsurance	Deductible and Coinsurance
Year)	B. L. 271	B 1 221
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory	D 1 (31) 10 :	D 1 10 .
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	Same as Substance Use Disorder
ividuical dervices and merapy	Services	Services
 Nicotine Addiction Classes & Alternative 	Not Covered	Not Covered
Therapy, such as Acupuncture	Not Govered	Not Govered
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	Same as any other Illness	Deductible and Coinsurance
to naturally healthy teeth. (treatment related to		
accidents must be provided within 12 months of the		
date of Injury)		
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,	Deductible and Coinsurance	Deductible and Coinsurance
anesthesia, Inpatient Hospital visits and other non-		
surgical Services.		
Pregnancy, Maternity and Newborn Care		
Pregnancy and Maternity (payment for	Deducatible and O	Deducatible as 10.
prenatal and postnatal care is included in	Deductible and Coinsurance	Deductible and Coinsurance
the payment for the delivery)		
Newborn Care (newborns are covered at high subject to the plane and linear to the plane and linea	Doductible and Cainage	Doductible and Cainaversa
birth, subject to the plans enrollment	Deductible and Coinsurance	Deductible and Coinsurance
provisions) NOTE: Dependent Daughter Maternity is Not Covered.		I
	anraccion corogning un to one year falle	ing a Prognancy or shildhirth
NOTE: The plan pays 100% for the initial postpartum d	epression screening up to one year follow	ing 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 15 sessions per diagnosis) Pulmonary Rehabilitation (Chronic lung disease is limited to 15 sessions	Deductible and Coinsurance	Deductible and Coinsurance
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.)	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 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 	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
15 sessions per Calendar Year) NOTE: Treatment limits stated for physical therapy, occup provided for Mental Health and/or Substance Use Disorde 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 	Deductible and Coinsurance	Deductible and Coinsurance
 Eye Exam Diagnostic (to diagnose an Illness) Preventive (routine exam including refraction) limited to one exam per Calendar Year 	See Physician Office Services Plan Pays 100%	See Physician Office Services Deductible and Coinsurance
Wigs	Not Covered	Not Covered
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36-054-01 revised 1/2026 98-756 1/2026

Deductible and Coinsurance

All Other Covered Services

Deductible and Coinsurance

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Retail — per 30-day supply		
Generic Drugs	Deductible and Coinsurance	Not Covered
Preferred Brand Name Drugs	Deductible and Coinsurance	Not Covered
Non-Preferred Brand Name Drugs	Deductible and Coinsurance	Not Covered
NOTE: A 90-day supply is available at an Extended Sup	pply Network pharmacy.	·
Home Delivery – per 90-day supply		
Generic Drugs	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) Preferred Specialty Drugs Non-Preferred Specialty Drugs 	Not Covered Not Covered	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	Deductible and Coinsurance up to a maximum of \$35	Not Covered
Preferred Brand Name Drugs	Deductible and Coinsurance up to a maximum of \$35	Not Covered
 Non-Preferred Brand Name Drugs 	Deductible and Coinsurance	Not Covered
This plan utilizes the Broad Network C and NetResults Performance Prescription Drug List (PDL).		

In-network Provider

Out-of-network Provider

Prescription Drugs

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.

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