Schedule of Benefits Summary

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

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. 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 • Family (Embedded*)	 $7,350 $14,700	 N/A N/A
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%	 N/A N/A
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays) • Individual • Family (Embedded*)	 $9,200 $18,400	 N/A 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.) 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 • Outpatient Surgical Services • Physical, Occupational and Speech Therapy • Telehealth/Virtual Care • Inpatient Facility Services • Manipulations and Adjustments • Urgent Care Services • Cardiac Rehabilitation • 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
Physician Office Services • Primary Care Physician Office Visit	$25 Copy then Deductible and Coinsurance	Not Covered
• Specialist Physician Office Visit	$40 Copy then Deductible and Coinsurance	Not Covered
• Physician Office Services provided in the office (with or without an office visit)	Applicable office visit copay	Not Covered
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	$25 Copy then Deductible and Coinsurance	Not Covered
• Mental Health	See Mental Health and/or Substance Use Disorder Services	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Not Covered
Urgent Care Services (a single copay applies to each urgent care visit)	$100 Copy then Deductible and Coinsurance	Not Covered
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, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Not Covered
• Surgical Services	Deductible and Coinsurance	Not Covered
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	$2500 Copy then Deductible and Coinsurance	Not Covered

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
Inpatient Services	$2500 Copay then Deductible and Coinsurance	Not Covered
Outpatient Services		
• Office Services	$25 Copay then Deductible and Coinsurance	Not Covered
• Telehealth/Virtual Care Services	$25 Copay then Deductible and Coinsurance	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Not Covered
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	Not Covered
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	Not Covered
• Treatment	Same as mental health	Not Covered
Biofeedback		
• Medical	Deductible and Coinsurance	Not Covered
• Mental Health	Same as mental health	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 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) Prosthetics and Orthotic Devices limited to $6,500 per member per year	Deductible and Coinsurance	Not Covered
Hearing Services		
• Bone Anchored Hearing Aids	Deductible and Coinsurance	Not Covered
• Cochlear Implants	Deductible and Coinsurance	Not Covered
• Hearing Aids (up to age 19, limited to $3,000 every 48 months.)	Deductible and Coinsurance	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)	Deductible and Coinsurance	Not Covered
• Home Infusion Therapy	Deductible and Coinsurance	Not Covered
• Skilled Nursing Care (limited to 8 hours per day, limited to 60 days per Calendar Year)	Deductible and Coinsurance	Not Covered
Hospice Services	Deductible and Coinsurance	Not Covered
Independent Laboratory		
• Diagnostic	Deductible and Coinsurance	Not Covered
• Preventive	Same as Preventive Services In-network level of benefits	Not Covered
Infertility		
• Services to Diagnose	Same as any other illness	Not Covered
• Treatment to Promote Fertility	Not Covered	Not Covered
Nicotine Addiction		
• Medical Services and Therapy	Same as Substance Use Disorder Services	Not Covered
• 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	Not Covered
Organ and Tissue Transplantation	Same as any other illness	Not Covered
Ostomy Supplies	Deductible and Coinsurance	Not Covered
Physician Professional Services Inpatient and Outpatient services, such as, 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)	Deductible and Coinsurance	Not Covered
• Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions)	Deductible and Coinsurance	Not Covered
NOTE: Dependent Daughter maternity 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 10 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 reduction 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 then Deductible and Coinsurance Deductible and Coinsurance	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 10 sessions per Calendar Year for both rehabilitative and habilitative services) • Speech therapy Services (limited to 10 sessions per Calendar Year) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit of 10 sessions per Calendar Year)	$40 Copay then Deductible and Coinsurance $40 Copay then Deductible and Coinsurance $40 Copay then Deductible and Coinsurance	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 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%	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		
• Preferred Generic Drugs	$10 Copay	Not Covered
• Preferred Brand Name Drugs	Not Covered	Not Covered
• Non-Preferred Brand Name Drugs	Not Covered	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	Not Covered	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	Not Covered
Diabetic Insulin		
• Preferred Generic Drugs	$10 Copay	Not Covered
• Preferred Brand Name Drugs	Not Covered	Not Covered
• Non-Preferred Brand Name Drugs	Not Covered	Not Covered

You can find this generic prescription drug list on Ventegra.com, or you may contact Member Services at the phone number on the back of your I.D. card.