GIGCARE
POWERED BY DETEGO HEALTH

PLAN COMPARISON SUMMARY

- GigCare PPO $1,500
- GigCare PPO $2,500
- GigCare EPO $5,000
- GigCare EPO $7,350
- GigCare PPO HSA $5,000 HDHP

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

600-1005-5

Population Science Management

GIGCARE

EXPLORE THE DIFFERENCE

600-1005-5

Schedule of Benefits Summary: Plan Comparison

Population Science Management | GIGCARE

BlueCross BlueShield Nebraska

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

PLAN	GIGCARE $1,500 (PPO)		GIGCARE $2,500 (PPO)		GIGCARE $5,000 (EPO)		GIGCARE $7,350 (EPO)		GIGCARE $5,000 (PPO / HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Payment for Services										
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. **PPO Plans: In some situations, Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.** **EPO Plans: There is no Out-of-Network coverage under these Plans.**										
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	$1,500	$3,000	$2,500	$5,000	$5,000	N/A	$7,350	N/A	$5,000	$10,000
• Family (Embedded*)	$3,000	$6,000	$5,000	$10,000	$10,000		$14,700		$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%	30%	50%	30%	N/A	30%	N/A	30%	50%
• Plan Pays	70%	50%	70%	50%	70%		70%		70%	50%
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays)										
• Individual	$7,350	$20,000	$7,350	$20,000	$7,350	N/A	$9,200	N/A	$6,550	$20,000
• Family (Embedded*)	$14,700	$40,000	$14,700	$40,000	$14,700		$18,400		$13,100	$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.										

Plans: GigCare PPO $1,500, GigCare PPO $2,500, GigCare EPO $5,000, GigCare EPO $7,350

Copayment(s) (copay(s)) apply to:

- Physician Office
- Urgent Care Facility
- Physical, Occupational and Speech Therapy Services
- Telehealth/Virtual Care
- Prescription Drugs
- Cardiac and Pulmonary Rehabilitation
- Manipulations and Adjustments

Plan: GigCare PPO HSA $5,000 HDHP

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.

Schedule of Benefits Summary: Plan Comparison

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Covered Services - Illness or Injury										
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	$25 Copay $40 Copay Applicable office visit copay	Deductible and Coinsurance	$25 Copay $40 Copay Applicable office visit copay	Not Covered	$25 Copay $40 Copay Applicable office visit copay	Not Covered	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	Same as in-person visit See Mental Health and/or Substance Use Disorder Services	Deductible and Coinsurance	Same as in-person visit See Mental Health and/or Substance Use Disorder Services	Deductible and Coinsurance	Same as in-person visit See Mental Health and/or Substance Use Disorder Services	Not Covered	Same as in-person visit See Mental Health and/or Substance Use Disorder Services	Not Covered	Ded. & Coin. 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	Same as a Primary Care Physician	Deductible and Coinsurance	Same as a Primary Care Physician	Not Covered	Same as a Primary Care Physician	Not Covered	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	$60 Copay	Deductible and Coinsurance	$75 Copay	Not Covered	$100 Copay	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room Services (services received in a hospital emergency room setting) • Facility • Professional Services	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits

Schedule of Benefits Summary: Plan Comparison

Population Science Management | GIGCARE

BlueCross BlueShield Nebraska

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

PLAN	GIGCARE $1,500 (PPO)		GIGCARE $2,500 (PPO)		GIGCARE $5,000 (EPO)		GIGCARE $7,350 (EPO)		GIGCARE $5,000 (PPO / HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Covered Services - Illness or Injury (Continued)										
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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services										
Preventive Services • Affordable Care Act (ACA) required preventive services (may by subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan pays 100% Same as any other illness Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness Same as any other illness	Not Covered	Plan pays 100% Same as any other illness Same as any other illness	Not Covered	Plan pays 100% Same as any other illness Same as any other illness	Deductible and Coinsurance
Immunizations • Pediatric (up to age 7) • Age 7 and older • Related to an illness	Plan pays 100% Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Plan pays 100% Same as any other illness	Deductible and Coinsurance

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Preventive Services (Continued)										
Colorectal Cancer Screenings (starting at age 45) • Colonoscopy Screening - Diagnostic or Preventive Screening (one every five years) - Screenings outside the age or frequency limit	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Deductible and Coinsurance
• Sigmoidoscopy/ Proctoscopy Screening and CT of the Colon - Preventive Screening (one every five years) - Screenings outside the age or frequency limit	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Deductible and Coinsurance
• FIT DNA - Preventive Screening (one every three years) - Screenings outside the age or frequency limit	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Deductible and Coinsurance
• Fecal occult blood test - Preventive Screening (one per year) - Screenings outside the age or frequency limit	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Deductible and Coinsurance
• Barium enema, and other tests as determined under ACA Preventive Services - Preventive Screenings - Diagnostic Screenings	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Deductible and Coinsurance	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% Same as any other illness	Not Covered	Plan pays 100% 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.

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Mental Health and/or Substance Use Disorder Services										
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services • Office Services	$25 Copay	Deductible and Coinsurance	$25 Copay	Deductible and Coinsurance	$25 Copay	Not Covered	$25 Copay	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth/Virtual Care Services	Same as in-person visit		Same as in-person visit		Same as in-person visit		Same as in-person visit			
• All other Outpatient Items and Services	Deductible and Coinsurance		Deductible and Coinsurance		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 • Professional Services	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits
Other Covered Services - Illness or Injury										
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	In-Network level of benefits	Deductible and Coinsurance	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	Same as mental health	Not Covered	Same as mental health	Not Covered	Same as mental health	Same as mental health

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued Part 1 of 6)										
Biofeedback • Medical • Mental Health	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health	Not Covered	Deductible and Coinsurance Same as mental health	Not Covered	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	Not Covered	Same as any other illness	Not Covered	Same as any other illness	Deductible and Coinsurance
Diabetic Services (services include education, self-management training, podiatric appliances and equipment)	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Not Covered	Same as any other illness	Not Covered	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	Same as any other illness	Same as any other illness	Same as any other illness	Not Covered	Same as any other illness	Not Covered	Same as any other illness	Deductible and Coinsurance
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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Services • Bone Anchored Hearing Aids • Cochlear Implants • Hearing Aids (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	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued Part 2 of 6)										
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	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services	Not Covered	Deductible and Coinsurance Same as Preventive Services	Not Covered	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services
Infertility • Services to Diagnose • Treatment to Promote Fertility	Same as any other illness Not Covered	Deductible and Coinsurance Not Covered	Same as any other illness Not Covered	Deductible and Coinsurance Not Covered	Same as any other illness Not Covered	Not Covered	Same as any other illness Not Covered	Not Covered	Same as any other illness Not Covered	Deductible and Coinsurance Not Covered
Nicotine Addiction • Medical Services and Therapy • Nicotine Addiction Classes and Alternative Therapy, such as Acupuncture	Same as Substance Use Disorder Services Not Covered	Same as Substance Use Disorder Services Not Covered	Same as Substance Use Disorder Services Not Covered	Same as Substance Use Disorder Services Not Covered	Same as Substance Use Disorder Services Not Covered	Not Covered	Same as Substance Use Disorder Services Not Covered	Not Covered	Same as Substance Use Disorder Services Not Covered	Deductible and Coinsurance Not Covered

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued Part 3 of 6)										
Obesity • Non-Surgical Treatment • Surgical Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	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	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Not Covered	Same as any other illness	Not Covered	Same as any other illness	Deductible and Coinsurance
Organ and Tissue Transplantation	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Not Covered	Same as any other illness	Not Covered	Same as any other illness	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
• 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	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	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.

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued Part 4 of 6)										
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Radiation (X-Ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services - Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services										
• Cardiac rehabilitation	$40 Copay (limit to 20 sessions per diagnosis)	Ded. & Coin. (limit to 20 sessions per diagnosis)	$40 Copay (limit to 20 sessions per diagnosis)	Ded. & Coin. (limit to 20 sessions per diagnosis)	$40 Copay (limit to 15 sessions per diagnosis)	Not Covered	$40 Copay (limit to 10 sessions per diagnosis)	Not Covered	Ded. & Coin. (limit to 15 sessions per diagnosis)	Ded. & Coin. (limit to 15 sessions per diagnosis)
• Pulmonary Rehabilitation	$40 Copay (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 are limited to 20 sessions following referral and prior to surgery plus 20 sessions within six months of discharge from hospital following surgery.)	Ded. & Coin. (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 are limited to 20 sessions following referral and prior to surgery plus 20 sessions within six months of discharge from hospital following surgery.)	$40 Copay (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 are limited to 20 sessions following referral and prior to surgery plus 20 sessions within six months of discharge from hospital following surgery.)	Ded. & Coin. (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 are limited to 20 sessions following referral and prior to surgery plus 20 sessions within six months of discharge from hospital following surgery.)	$40 Copay (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 are limited to 15 sessions following referral and prior to surgery plus 15 sessions within six months of discharge from hospital following surgery.)	Not Covered	$40 Copay (Chronic lung disease is limited to 10 sessions per diagnosis, not to exceed 10 sessions per calendar year. Lung, heart-lung transplants and lung volume are limited to 10 sessions following referral and prior to surgery plus 10 sessions within six months of discharge from hospital following surgery.)	Not Covered	Ded. & Coin. (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 are limited to 15 sessions following referral and prior to surgery plus 15 sessions within six months of discharge from hospital following surgery.)	Ded. & Coin. (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 are limited to 15 sessions following referral and prior to surgery plus 15 sessions within six months of discharge from hospital following surgery.)
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Sexual Dysfunction	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Schedule of Benefits Summary: Plan Comparison

Population Science Management | GIGCARE

BlueCross BlueShield Nebraska

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

PLAN	GIGCARE $1,500 (PPO)		GIGCARE $2,500 (PPO)		GIGCARE $5,000 (EPO)		GIGCARE $7,350 (EPO)		GIGCARE $5,000 (PPO / HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued Part 5 of 6)										
Skilled Nursing Facility (limited to 60 days per calendar year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Deductible and Coinsurance	Same as any other illness	Not Covered	Same as any other illness	Not Covered	Same as any other illness	Deductible and Coinsurance
Therapy and Manipulations										
• Physical and occupational therapy Services, chiropractic or osteopathic physiotherapy	$40 Copay (combined limit of 20 sessions per calendar year for both rehabilitative and habilitative services)	Ded. & Coin. (combined limit of 20 sessions per calendar year for both rehabilitative and habilitative services)	$40 Copay (combined limit of 20 sessions per calendar year for both rehabilitative and habilitative services)	Ded. & Coin. (combined limit of 20 sessions per calendar year for both rehabilitative and habilitative services)	$40 Copay (combined limit of 15 sessions per calendar year for both rehabilitative and habilitative services)	Not Covered	$40 Copay (combined limit of 10 sessions per calendar year for both rehabilitative and habilitative services)	Not Covered	Ded. & Coin. (combined limit of 15 sessions per calendar year for both rehabilitative and habilitative services)	Ded. & Coin. (combined limit of 15 sessions per calendar year for both rehabilitative and habilitative services)
• Speech therapy Services	$40 Copay (limited to 20 sessions per calendar year)	Ded. & Coin. (limited to 20 sessions per calendar year)	$40 Copay (limited to 20 sessions per calendar year)	Ded. & Coin. (limited to 20 sessions per calendar year)	$40 Copay (limited to 15 sessions per calendar year)	Not Covered	$40 Copay (limited to 10 sessions per calendar year)	Not Covered	Ded. & Coin. (limited to 15 sessions per calendar year)	Ded. & Coin. (limited to 15 sessions per calendar year)
• Chiropractic or osteopathic manipulative treatments or adjustments	$40 Copay (combined limit of 20 sessions per calendar year)	Ded. & Coin. (combined limit of 20 sessions per calendar year)	$40 Copay (combined limit of 20 sessions per calendar year)	Ded. & Coin. (combined limit of 20 sessions per calendar year)	$40 Copay (combined limit of 15 sessions per calendar year)	Not Covered	$40 Copay (combined limit of 10 sessions per calendar year)	Not Covered	Ded. & Coin. (combined limit of 15 sessions per calendar year)	Ded. & Coin. (combined limit of 15 sessions per calendar year)

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.

Schedule of Benefits Summary: Plan Comparison

Population Science Management | GIGCARE

BlueCross BlueShield Nebraska

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

PLAN	GIGCARE $1,500 (PPO)		GIGCARE $2,500 (PPO)		GIGCARE $5,000 (EPO)		GIGCARE $7,350 (EPO)		GIGCARE $5,000 (PPO / HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued Part 6 of 6)										
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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance
• Vision Exam - Diagnostic (to diagnose an illness)	See Physician Office Service	See Physician Office Service	See Physician Office Service	See Physician Office Service	See Physician Office Service	Not Covered	See Physician Office Service	Not Covered	See Physician Office Service	See Physician Office Service
- Preventive (routine exam including refraction) limited to one exam per calendar year	Plan Pays 100%	Deductible and Coinsurance	Plan Pays 100%	Deductible and Coinsurance	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Deductible and Coinsurance
Wigs	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Deductible and Coinsurance

Schedule of Benefits Summary: Plan Comparison

Population Science Management | GIGCARE

BlueCross BlueShield Nebraska

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2025

PLAN	GIGCARE $1,500 (PPO)		GIGCARE $2,500 (PPO)		GIGCARE $5,000 (EPO)		GIGCARE $7,350 (EPO)		GIGCARE $5,000 (PPO / HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Prescription Drugs										
Retail - per 30 day supply • Generic Drugs • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs	$10 Copay $45 Copay $105 Copay	Not Covered	$10 Copay $45 Copay $105 Copay	Not Covered	$10 Copay $105 Copay Not Covered	Not Covered	$10 Copay $105 Copay Not Covered	Not Covered	Deductible and Coinsurance	Not Covered
NOTE: A 90 day supply is available at an Extended Supply Network pharmacy.										
Home Delivery - per 90 day supply • Generic Drugs • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs	$30 Copay $135 Copay $315 Copay	Not Covered	$30 Copay $135 Copay $315 Copay	Not Covered	$30 Copay $315 Copay Not Covered	Not Covered	$30 Copay $315 Copay Not Covered	Not Covered	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	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptive Drugs • Contraceptive Drugs and Methods in accordance with Federal Guidelines • All other Contraceptive Drugs and Methods	Plan Pays 100% Same as any other Generic or Brand Name Drugs	Not Covered	Plan Pays 100% Same as any other Generic or Brand Name Drugs	Not Covered	Plan Pays 100% Same as any other Generic or Brand Name Drugs	Not Covered	Plan Pays 100% Same as any other Generic or Brand Name Drugs	Not Covered	Plan Pays 100% Same as any other Generic or Brand Name Drugs	Not Covered
Diabetic Insulin • Generic Drugs • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs	$10 Copay $35 Copay $85 Copay	Not Covered	$10 Copay $35 Copay $85 Copay	Not Covered	$10 Copay $35 Copay Not Covered	Not Covered	$10 Copay $35 Copay Not Covered	Not Covered	Ded. & Coin. (Up to $35) Ded. & Coin. (Up to $35) Ded. & Coin.	Not Covered

Plans: GigCare PPO $1,500, GigCare PPO $2,500, GigCare PPO HSA $5,000 HDHP

These plans utilize the Broad Network C and NetResults Performance prescription drug list (PDL) 40.

Plans: GigCare EPO $5,000, GigCare EPO $7,350

These plans utilize the Broad Network C and prescription drug list (PDL) 10.

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.

THANK YOU

Population Science Management

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