Population Science Management

PLAN COMPARISON

Thrive PPO Plans

- $1,500
- $2,500
- $5,000 HDHP (HSA)

Thrive EPO Plans

- $5,000
- $7,350

January 1, 2026 - January 1, 2027

Major Medical Plan

600-1005-6

Disclaimer for Population Science Management of Working Owners

Population Science Management (PSM), a data analytics company dedicated to empowering individuals to financially benefit from the sharing their personal data, is actively hiring Consumer Data Respondents (CDRs).

As a CDR, you would provide insights into your health and consumer habits, and will be a member of PSM subject to the terms and conditions of the PSM Operating Agreement. You would become a "Working Owner" of the company.

One of the terms and conditions of Working Ownership is that you agree to share select data through our Covered365 app, available on both Apple App Store and Google Play.

As a Working Owner, you are expected to complete tasks as they arise, most of which consist of short but impactful surveys. The frequency of these requests varies depending on several factors and may range from once per quarter to as often as once per month during the first year. All surveys provide compensation, though amounts may vary, with some offering higher rewards than others.

Working Owners are eligible to participate in the company's employee benefit plans, including the single-employer self-funded ERISA group health plan (collectively referred to as "GigCare") and other benefits made available to similarly situated Working Owners, contingent upon timely payment of health benefits contributions, the terms of the Operating Agreement, and the terms of the plan documents. Your contributions play a significant role in advancing our mission to improve health care, and we value the impact of your work.

Population Science Management

This illustration describes the plan in an easily understood manner and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan; and it is not to be considered a policy of insurance.

Subject to plan allowable The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.detegohealth.com or call 1-866-815-6001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.com or www.cciio.cms.gov

Schedule of Benefits Summary: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plan	THRIVE $1,500 (PPO)		THRIVE $2,500 (PPO)		THRIVE $5,000 (EPO)		THRIVE $7,350 (EPO)		THRIVE $5,000 (PPO / HSA)	
NETWORK	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
In-network Provider: Blue Cross and Blue Shield of Nebraska										

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.

	THRIVE $1,500 (PPO) IN	THRIVE $1,500 (PPO) OUT	THRIVE $2,500 (PPO) IN	THRIVE $2,500 (PPO) OUT	THRIVE $5,000 (EPO) IN	THRIVE $5,000 (EPO) OUT	THRIVE $7,350 (EPO) IN	THRIVE $7,350 (EPO) OUT	THRIVE $5,000 (PPO / HSA) IN	THRIVE $5,000 (PPO / HSA) OUT
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	$1,500 $3,000	$3,000 $6,000	$2,500 $5,000	$5,000 $10,000	$5,000 $10,000	N/A	$7,350 $14,700	N/A	$5,000 $10,000	$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 • Plan Pays	30% 70%	50% 50%	30% 70%	50% 50%	30% 70%	N/A	30% 70%	N/A	30% 70%	50% 50%
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays) • Individual • Family (Embedded*)	$8,500 $17,000	$20,000 $40,000	$8,500 $17,000	$20,000 $40,000	$7,350 $14,700	N/A	$9,200 $18,400	N/A	$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.) 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: Thrive PPO $1,500, Thrive PPO $2,500, Thrive EPO $5,000, Thrive 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: Thrive 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.

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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	$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

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.

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.)*

Major Medical Plan	THRIVE $1,500 (PPO) IN	THRIVE $1,500 (PPO) OUT	THRIVE $2,500 (PPO) IN	THRIVE $2,500 (PPO) OUT	THRIVE $5,000 (EPO) IN	THRIVE $5,000 (EPO) OUT	THRIVE $7,350 (EPO) IN	THRIVE $7,350 (EPO) OUT	THRIVE $5,000 (PPO / HSA) IN	THRIVE $5,000 (PPO / HSA) OUT
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

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Covered Services - Illness or Injury (Continued)										
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	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 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	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		Deductible and Coinsurance		Deductible and Coinsurance		Not Covered		Not Covered		Deductible and Coinsurance
• Affordable Care Act (ACA) required preventive services (may by subject to limits that include, but are not limited to, age, gender, and frequency)	Plan pays 100%		Plan pays 100%		Plan pays 100%		Plan pays 100%		Plan pays 100%	
• ACA required covered preventive services (outside of limits)	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	
• Other covered preventive services not required by ACA	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	
Immunizations		Deductible and Coinsurance		Deductible and Coinsurance		Not Covered		Not Covered		Deductible and Coinsurance
• Pediatric (up to age 7)	Plan pays 100%		Plan pays 100%		Plan pays 100%		Plan pays 100%		Plan pays 100%	
• Age 7 and older	Plan pays 100%		Plan pays 100%		Plan pays 100%		Plan pays 100%		Plan pays 100%	
• Related to an illness	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	

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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)	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
- Screenings outside the age or frequency limit	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	
• Sigmoidoscopy/ Proctoscopy Screening and CT of the Colon - Preventive Screening (one every five years)	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
- Screenings outside the age or frequency limit	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	
• FIT DNA - Preventive Screening (one every three years)	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
- Screenings outside the age or frequency limit	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	
• Fecal occult blood test - Preventive Screening (one per 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
- Screenings outside the age or frequency limit	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	
• Barium enema, and other tests as determined under ACA Preventive Services - Preventive Screenings	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
- Diagnostic Screenings	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	

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 Visit	$25 Copay		$25 Copay		$25 Copay		$25 Copay			
• Office Services	Applicable Office Visit Copay	Deductible and Coinsurance	Applicable Office Visit Copay	Deductible and Coinsurance	Applicable Office Visit Copay	Not Covered	Applicable Office Visit 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			
Benefits for **office visit** include the **office visit**, medication checks, psychological therapy and/or Substance Use Disorder counseling. The following **office Services** are available when provided in the office; X-rays, laboratory tests, supplies and/or drugs administered during the **office visit**. 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.										
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

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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)										
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
Biofeedback • Medical	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
• Mental Health	Same as mental health	Same as mental health	Same as mental health	Same as mental health	Same as mental health		Same as mental health		Same as mental health	
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 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, which-ever 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 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	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	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	Same as Preventive Services	Same as Preventive Services	Same as Preventive Services	Same as Preventive Services	Same as Preventive Services		Same as Preventive Services		Same as Preventive Services	Same as Preventive Services
Infertility										
• Services to Diagnose	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
• Treatment to Promote Fertility	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered		Not Covered		Not Covered	Not Covered
Nicotine Addiction										
• Medical Services and Therapy	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services	Not Covered	Same as Substance Use Disorder Services	Not Covered	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services
• Nicotine Addiction Classes and Alternative Therapy, such as Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered		Not Covered		Not Covered	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 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	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.

Schedule of Benefits Summary: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plan	THRIVE $1,500 (PPO)		THRIVE $2,500 (PPO)		THRIVE $5,000 (EPO)		THRIVE $7,350 (EPO)		THRIVE $5,000 (PPO / HSA)	
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: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plan	THRIVE $1,500 (PPO)		THRIVE $2,500 (PPO)		THRIVE $5,000 (EPO)		THRIVE $7,350 (EPO)		THRIVE $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 Disorder Services. Evaluations are covered but do not apply to the combined calendar year limit.

Schedule of Benefits Summary: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plan	THRIVE $1,500 (PPO)		THRIVE $2,500 (PPO)		THRIVE $5,000 (EPO)		THRIVE $7,350 (EPO)		THRIVE $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 due to 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
• Eye 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: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plan	THRIVE $1,500 (PPO)		THRIVE $2,500 (PPO)		THRIVE $5,000 (PPO / HSA)	
NETWORK	IN	OUT	IN	OUT	IN	OUT
Prescription Drugs						
Retail - 30 day supply		Not Covered		Not Covered	Deductible and Coinsurance	Not Covered
• Generic	25%, $10 Minimum/ $450 Maximum		25%, $10 Minimum/ $450 Maximum			
• Preferred	25%, $45 Minimum/ $450 Maximum		25%, $45 Minimum/ $450 Maximum			
• Non-preferred	25%, $105 Minimum/ $450 Maximum		25%, $105 Minimum/ $450 Maximum			
NOTE: A 90 day supply is available at an Extended Supply Network pharmacy for the PPO Plans.						
Home Delivery - 90 day supply		Not Covered		Not Covered	Deductible and Coinsurance	Not Covered
• Generic	25%, $30 Minimum/ $1,350 Maximum		25%, $30 Minimum/ $1,350 Maximum			
• Preferred	25%, $135 Minimum/ $1,350 Maximum		25%, $135 Minimum/ $1,350 Maximum			
• Non-preferred	25%, $315 Minimum/ $1,350 Maximum		25%, $315 Minimum/ $1,350 Maximum			
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
Contraceptive Drugs		Not Covered		Not Covered		Not Covered
• Contraceptive Drugs and Methods in accordance with Federal Guidelines	Plan Pays 100%		Plan Pays 100%		Plan Pays 100%	
• All other Contraceptive Drugs and Methods	Same as any other Generic or Brand Name Drugs		Same as any other Generic or Brand Name Drugs		Same as any other Generic or Brand Name Drugs	
Diabetic Insulin		Not Covered		Not Covered		Not Covered
• Generic Drugs	$10 Copay		$10 Copay		Ded. & Coin. (Up to $35)	
• Preferred Brand Name Drugs	$35 Copay		$35 Copay		Ded. & Coin. (Up to $35)	
• Non-preferred Brand Name Drugs	$85 Copay		$85 Copay		Ded. & Coin.	

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

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.

Schedule of Benefits Summary: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plan	THRIVE $5,000 (EPO)		THRIVE $7,350 (EPO)	
NETWORK	IN	OUT	IN	OUT
Prescription Drugs				
Retail - 30 day supply		Not Covered		Not Covered
• Generic	25%, $10 Minimum/ $450 Maximum		25%, $10 Minimum/ $450 Maximum	
• Preferred	25%, $105 Minimum/ $450 Maximum		25%, $105 Minimum/ $450 Maximum	
• Non-preferred	Not Covered		Not Covered	
Home Delivery - 90 day supply		Not Covered		Not Covered
• Generic	25%, $30 Minimum/ $1,350 Maximum		25%, $30 Minimum/ $1,350 Maximum	
• Preferred	25%, $315 Minimum/ $1,350 Maximum		25%, $315 Minimum/ $1,350 Maximum	
• Non-preferred	Not Covered		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		Not Covered		Not Covered
• Contraceptive Drugs and Methods in accordance with Federal Guidelines	Plan Pays 100%		Plan Pays 100%	
• All other Contraceptive Drugs and Methods	Same as any other Generic or Brand Name Drugs		Same as any other Generic or Brand Name Drugs	
Diabetic Insulin		Not Covered		Not Covered
• Generic Drugs	$10 Copay		$10 Copay	
• Preferred Brand Name Drugs	$35 Copay		$35 Copay	
• Non-preferred Brand Name Drugs	Not Covered		Not Covered	

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

This plan utilizes the Broad Network C and BlueChoice Meds 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.

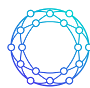
Schedule of Benefits Summary: Thrive Plan Comparison

Group Name: Population Science Management of Nebraska

Effective Date: January 1, 2026 - January 1, 2027

Major Medical Plans · PPO / EPO / HSA · Monthly Contributions					
PLAN	**THRIVE $1,500 (PPO)**	**THRIVE $2,500 (PPO)**	**THRIVE $5,000 (EPO)**	**THRIVE $7,350 (EPO)**	**THRIVE $5,000 (PPO / HSA)**
AGES 18-29					
Employee	$881.05	$821.97	$692.17	$600.92	$631.37
Employee + Spouse	$1,631.59	$1,513.43	$1,254.27	$1,071.77	$1,131.58
Employee + Child(ren)	$1,483.52	$1,377.18	$1,143.89	$979.64	$1,033.58
Family	$2,387.67	$2,210.43	$1,821.91	$1,548.16	$1,637.32
AGES 30-44					
Employee	$910.77	$849.32	$714.35	$619.45	$651.07
Employee + Spouse	$1,691.03	$1,568.14	$1,298.64	$1,108.83	$1,170.99
Employee + Child(ren)	$1,537.02	$1,426.42	$1,183.82	$1,013.00	$1,069.05
Family	$2,476.83	$2,292.50	$1,888.46	$1,603.75	$1,696.44
AGES 45-54					
Employee	$955.39	$890.36	$742.02	$642.57	$675.66
Employee + Spouse	$1,780.70	$1,650.65	$1,353.98	$1,155.07	$1,220.16
Employee + Child(ren)	$1,617.68	$1,500.63	$1,233.63	$1,054.61	$1,113.30
Family	$2,611.55	$2,416.48	$1,971.47	$1,673.11	$1,770.19
AGES 55-64					
Employee	$1,068.28	$994.28	$798.85	$690.04	$726.14
Employee + Spouse	$2,006.49	$1,858.48	$1,467.63	$1,250.02	$1,321.12
Employee + Child(ren)	$1,820.89	$1,687.68	$1,335.91	$1,140.06	$1,204.17
Family	$2,950.24	$2,728.23	$2,141.95	$1,815.53	$1,921.64

THANK YOU



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