GIGCARE
POWERED BY DETEGO HEALTH

PLAN COMPARISON SUMMARY

Major Medical Plan
Effective Date: 11/01/2025

EPO Plans:

- **Livelihood $1,800**
- **Livelihood $3,750**
- **Livelihood $4,500**
- **Livelihood $6,800**
- **Livelihood $8,300**
- **Livelihood $6,500 HDHP (HSA)**

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

Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025

Major Medical Plan	EPO $1,800		EPO $3,750		EPO $4,500		EPO $6,800		EPO $8,300		EPO $6,500 HDHP (HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
In-network Provider: Aetna												
Payment for Services												
Covered Services are reimbursed based on the Allowable Charge. 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 can't bill for amounts over the Contracted Amount. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network allowance. Cost-sharing and reimbursement amounts for categories showing "Same as any other illness" may vary based on where services are rendered. **EPO Plans: There is no Out-of-Network coverage under these Plans.**												
Deductible (the amount the Covered Person pays each Benefit Period for Covered Services before the Coinsurance is payable)												
• Individual	$1,800	Not Covered	$3,750	Not Covered	$4,500	Not Covered	$6,800	Not Covered	$8,300	Not Covered	$6,500	Not Covered
• Family Unit*	$3,600		$7,500		$9,000		$13,600		$16,600		$13,000	
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)												
• Covered Person Pays	25%	Not Covered	25%	Not Covered	25%	Not Covered	25%	Not Covered	25%	Not Covered	25%	Not Covered
• Plan Pays	75%		75%		75%		75%		75%		75%	
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays)												
• Individual	$9,200	Not Covered	$9,200	Not Covered	$9,200	Not Covered	$9,200	Not Covered	$9,200	Not Covered	$8,300	Not Covered
• Family Unit*	$18,400		$18,400		$18,400		$18,400		$18,400		$16,600	
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. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the benefit period.												
*Unit/Accumulated – If you have family coverage, there is no individual Deductible or Out-of-pocket Limit. The total family Deductible and Out-of-pocket Limit must be met before the plan begins to pay for any covered services for any family member. All covered family members' expenses combine to meet these family amounts, and a single family member may contribute the entire total.												
Copays Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.												
Plans: EPO $1,800, EPO $3,750, EPO $4,500, EPO $6,800, EPO $8,300 **Copayment(s) (copay(s)) apply to:** • Physician Office • Specialist Office • Urgent Care Facility • Physical, Occupational and Speech Therapy Services • Cardiac Rehabilitation • Manipulations • Routine Vision Exam • Prenatal/Postnatal Office • Mental Health/Substance Abuse/ Autism Outpatient & Office • Prescription Drugs												
Plan: EPO $6,500 HDHP (HSA) **Copayment(s) (copay(s)) apply to:** • This plan has no medical or prescription copays												
The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.												
All Benefits Payable Under This Plan Are Subject To The Plan Allowable.												
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**
Covered Services - Illness or Injury						
Physician Office Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Urgent Care Visit - 4 visits limit per benefit period.	$40 Copay $70 Copay $85 Copay	Not Covered	$40 Copay $70 Copay $85 Copay	Not Covered	Deductible and Coinsurance	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 (through MyLiveDoc telehealth platform.) • Virtual Primary Care - Unlimited • Urgent Care - Unlimited • Mental Health (Triage) - 4 visits limit per benefit period.	$0 Copay, $0 Deductible through MyLiveDoc Telehealth platform $40 Copay for all other Telehealth platforms	Not Covered	$0 Copay, $0 Deductible through MyLiveDoc Telehealth platform $40 Copay for all other Telehealth platforms	Not Covered	$0 Copay, $0 Deductible through MyLiveDoc Telehealth platform Deductible and Coinsurance for all other Telehealth platforms	Not Covered
NOTE: $0 copay applies only to Virtual Visits conducted through the MyLiveDoc Telehealth Platform. This does not include telemedicine services provided by your personal physician. Telemedicine visits through your physician are billed as Physician Office Services.						
Emergency Room Services (services received in a hospital emergency room setting) • Facility • Professional Services	Deductible and Coinsurance (waived if admitted)	Same as In-Network Benefit for Emergent Situations / Non-Emergent Situations are Not Covered	Deductible and Coinsurance (waived if admitted)	Same as In-Network Benefit for Emergent Situations / Non-Emergent Situations are Not Covered	Deductible and Coinsurance	Same as In-Network Benefit for Emergent Situations / Non-Emergent Situations are Not Covered

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NETWORK	**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 rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	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	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Preventive Services						
Preventive Care/ Screenings • 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	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	Not Covered
Immunizations • Child • Adult	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Child Dentistry and Eye Care						
Child Eye Exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Child Glasses/ Contacts	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Child Dental Check Up	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Mental Health, Behavioral Health, and/or Substance Use Disorder Services						
Inpatient Services Paid at the facility's semi-privateroom rate.	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Outpatient Services • Office Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Partial Hospitalization	Deductible and Coinsurance (10 Days per Benefit Period)	Not Covered	Deductible and Coinsurance (10 Days per Benefit Period)	Not Covered	Deductible and Coinsurance (10 Days per Benefit Period)	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.						
Pregnancy / Maternity						
Pregnancy and Maternity (Dependent daughter pregnancy is not covered.) • Routine Vaginal Delivery • Routine C-Section Delivery • Inpatient Facility	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance; Deductible and $2,500 Copay	Not Covered	Deductible and Coinsurance	Not Covered
• Professional Services	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
• Prenatal/Postnatal Office Visits	100% Covered	Not Covered	100% Covered	Not Covered	Deductible and Coinsurance	Not Covered
• All Other Maternity Services	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
• NICU - Up to 5 Days	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	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						
Advanced Diagnostic Imaging (CT, MRI, MRA, PET scans) Stand-alone X-Ray/ Imaging Center Only - except during Inpatient/ E.R. Admissions	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered

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Effective Date: November 1, 2025

Major Medical Plan	EPO $1,800 / $3,750		EPO $4,500 / $6,800 / $8,300		EPO HDHP (HSA) $6,500	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued 1 of 2)						
Allergies • Shots • Visits/Testing	$40 Copay $40 for Physician Visit / Deductible and Coinsurance for Testing	Not Covered	$40 Copay $40 for Physician Visit / Deductible and Coinsurance for Testing	Not Covered	Deductible and Coinsurance	Not Covered
Ambulance (to the nearest facility for appropriate care). Limit to 1 per Benefit Period.	$1,000.00 Indemnity Benefit after Deductible	Same as In-Network Benefit for Emergent Situations / Non-Emergent Situations are Not Covered	$1,000.00 Indemnity Benefit after Deductible	Same as In-Network Benefit for Emergent Situations / Non-Emergent Situations are Not Covered	Deductible and Coinsurance	Same as In-Network Benefit for Emergent Situations / Non-Emergent Situations are Not Covered
Diabetic Services • Nutritional Counseling - 1 per Benefit Period. • Supplies / Equipment	$40 Copay $0 Copay w/DiaThrive	Not Covered	$40 Copay $0 Copay w/DiaThrive	Not Covered	Deductible and Coinsurance $0 Copay w/DiaThrive	Not Covered
Diagnostic Test (X-Ray, Lab, EKGs, ECGs, All other diagnostic services not included in Imaging). Stand-alone X-Ray/ Imaging Center Only - except during Inpatient/ E.R. Admissions	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Diagnostic Lab Stand-alone Lab/Physican Office Only - except during Inpatient/E.R. Admissions	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Dialysis	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Durable Medical Equipment and Supplies (including Prosthetics) ($500 Max per Benefit Period)	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Home Health Care (limited to 8 visits per Benefit Period)	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Hospice Services (limited to 32 hours per Benefit Period)	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered

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NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued 2 of 2)						
Infusion/Injection Drugs	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Organ Transplants	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prosthetics and Orthotic ($1,000 Max per Benefit Period)	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Radiation/Chemo	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Rehabilitation, Therapy and Manipulation Services (combined limit of 25 sessions per Benefit Period) • Mental Health, Behavioral Health, Substance Abuse Disorder Services • Physical and occupational therapy Services. • Speech therapy Services • Spinal Manipulation Chiropractic treatments or adjustments. • Cardiac rehabilitation • Pulmonary rehabilitation	$40 Copay	Not Covered	$40 Copay	Not Covered	Deductible and Coinsurance	Not Covered
Skilled Nursing (limited to 8 visits per Benefit Period)	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
All Other Covered Services	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered

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Effective Date: November 1, 2025

Major Medical Plan	EPO $1,800 / $3,750		EPO $4,500 / $6,800 / $8,300		EPO HDHP (HSA) $6,500	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Prescription Drugs						
Retail - per 30 day supply						
• Preventive Medicine (Generic Only).	$0 copay	Not Covered*	$0 copay	Not Covered*	Deductible and Coinsurance	Not Covered*
• Generic Drugs	$20 copay	Not Covered*	$20 copay	Not Covered*	Deductible and Coinsurance	Not Covered*
• Preferred Brand and Non-preferred Name Drugs	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*
• Specialty Drugs	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*
Mail Order - per 90 day supply						
• Generic Drugs (30-Day Supply)	$30 copay	Not Covered*	$30 copay	Not Covered*	Deductible and Coinsurance	Not Covered*
• Generic Drugs (60-Day Supply)	$50 copay	Not Covered*	$50 copay	Not Covered*	Deductible and Coinsurance	Not Covered*
• Generic Drugs (90-Day Supply)	$60 copay	Not Covered*	$60 copay	Not Covered*	Deductible and Coinsurance	Not Covered*
• Preferred Brand and Non-preferred Name Drugs	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*
• Specialty Drugs	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*

Pharmacy Benefit Manager: These plans utilize Kroger Health.

90-Day Mail Order Supply: You can order a 90-day supply of your prescriptions through the **Kroger Mail Order Pharmacy** for convenient home delivery. Set up your mail-order service by visiting **kpp-rx.com** or by calling **800-482-1285** to speak with a Kroger Prescription Plans representative. Kroger Mail Order Pharmacy hours: Monday – Friday, 8:00 AM – 11:00 PM (ET) and Saturday – Sunday, 8:00 AM – 6:30 PM (ET).

Home Delivery (Alternative Option): If your prescription is not included on the Kroger drug list, you may use **ScriptCo** as a secondary option for affordable access. **Detego Health covers your ScriptCo membership** and contributes **$6.00** toward each generic prescription; members pay any remaining cost. **ScriptCo is not a formulary and does not have a restricted drug list**—members can purchase most FDA-approved prescriptions at transparent, wholesale prices. To get started, claim your membership using the email from ScriptCo. Prescribers may send prescriptions via **E-Scribe** or **fax** to **254-424-9800**. For questions or assistance using ScriptCo's home delivery services, call 888-201-0334.

***NOTE:** Excluded or non-covered medications may be available separately through our ancillary partner, ScriptAide, via their Patient Assistance Program (PAP) or Self-Pay Importation Program (SPIP). To learn more or check eligibility, call 866-837-1515 or email info@scriptaide.com.

***NOTE:** Your ScriptCo Membership may offer Preferred Brand Name Drugs and Non-Preferred Brand Name Drugs at 100% member responsibility.

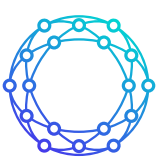
Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025

Major Medical Plans · EPO / HSA · Monthly Contributions						
PLAN	**LIVELIHOOD $1,800**	**LIVELIHOOD $3,750**	**LIVELIHOOD $4,500**	**LIVELIHOOD $6,800**	**LIVELIHOOD $8,350**	**LIVELIHOOD $6,500 (HSA)**
AGES 18-29						
Employee	$704.90	$635.04	$620.70	$552.82	$524.74	$581.07
Employee + Spouse	$1,191.38	$1,084.05	$1,069.96	$942.13	$881.77	$991.58
Employee + Child(ren)	$1,106.81	$1,007.10	$985.80	$869.70	$815.94	$921.20
Family	$1,685.67	$1,533.81	$1,524.06	$1,336.07	$1,243.55	$1,416.40
AGES 30-44						
Employee	$762.18	$693.51	$647.60	$576.27	$546.41	$613.50
Employee + Spouse	$1,332.10	$1,212.09	$1,121.05	$986.44	$922.45	$1,072.25
Employee + Child(ren)	$1,227.13	$1,116.58	$1,032.14	$909.92	$852.90	$987.76
Family	$1,812.88	$1,649.56	$1,599.42	$1,401.31	$1,303.32	$1,524.91
AGES 45-54						
Employee	$832.50	$757.50	$708.75	$636.33	$609.89	$698.62
Employee + Spouse	$1,425.42	$1,297.00	$1,229.16	$1,091.18	$1,031.66	$1,196.18
Employee + Child(ren)	$1,363.55	$1,252.99	$1,176.63	$1,036.27	$981.99	$1,144.27
Family	$1,975.27	$1,797.31	$1,754.75	$1,551.04	$1,458.61	$1,657.61
AGES 55-64						
Employee	$925.65	$842.26	$786.59	$711.03	$687.02	$768.69
Employee + Spouse	$1,586.00	$1,443.11	$1,380.96	$1,234.99	$1,178.10	$1,337.87
Employee + Child(ren)	$1,516.63	$1,393.66	$1,319.46	$1,170.51	$1,118.98	$1,259.47
Family	$2,273.55	$2,089.20	$2,040.40	$1,799.53	$1,708.22	$1,987.40

Notes



Population Science Management