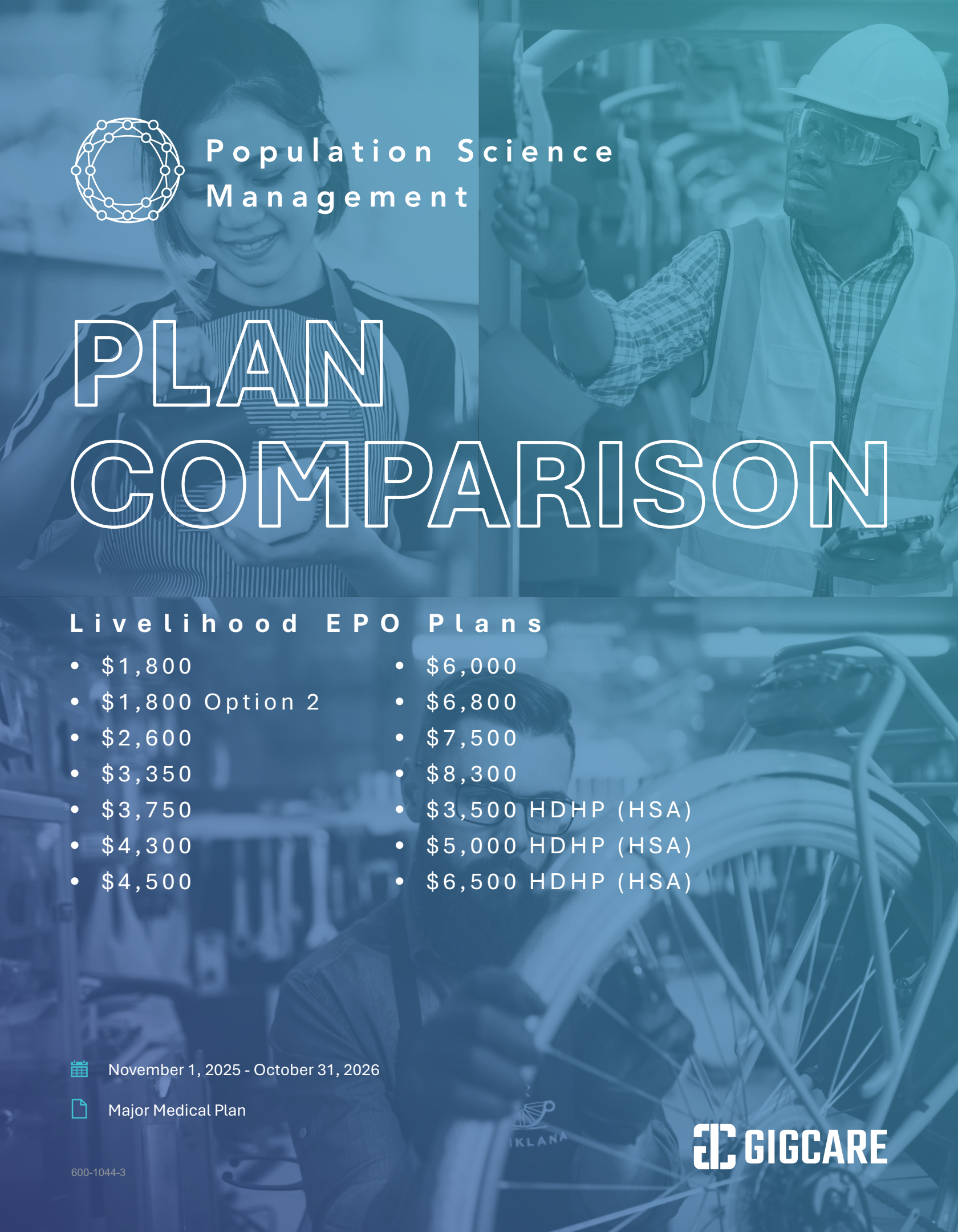

Population Science Management

# PLAN COMPARISON

## Livelihood EPO Plans

- $1,800
- $1,800 Option 2
- $2,600
- $3,350
- $3,750
- $4,300
- $4,500
- $6,000
- $6,800
- $7,500
- $8,300
- $3,500 HDHP (HSA)
- $5,000 HDHP (HSA)
- $6,500 HDHP (HSA)

November 1, 2025 - October 31, 2026

Major Medical Plan

GIGCARE

600-1044-3

# 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.

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 - October 31, 2026

| Major Medical Plan | EPO $1,800 | | EPO $1,800 Option 2 | | EPO $2,600 | | EPO $3,350 | | EPO $3,750 | | EPO $4,300 | | EPO $4,500 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NETWORK** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** |
| **In-network Provider:** Aetna EPO | | | | | | | | | | | | | | |
| **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 | $1,800 | Not Covered | $2,600 | Not Covered | $3,350 | Not Covered | $3,750 | Not Covered | $4,300 | Not Covered | $4,500 | Not Covered |
| • Family Unit* | $3,600 | | $3,600 | | $3,600 | | $6,700 | | $7,500 | | $8,600 | | $9,000 | |
| **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 | 20% | Not Covered | 20% | Not Covered | 20% | Not Covered | 25% | Not Covered | 20% | Not Covered | 25% | Not Covered |
| • Plan Pays | 75% | | 80% | | 80% | | 80% | | 75% | | 80% | | 75% | |
| **Out-of-Pocket Limit** (includes Deductible, Coinsurance and Copays) | | | | | | | | | | | | | | |
| • Individual | $9,200 | Not Covered | $10,000 | Not Covered | $10,000 | Not Covered | $10,000 | Not Covered | $9,200 | Not Covered | $10,000 | Not Covered | $9,200 | Not Covered |
| • Family Unit* | $18,400 | | $20,000 | | $20,000 | | $20,000 | | $18,400 | | $20,000 | | $18,400 | |
| 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. | | | | | | | | | | | | | | |
| **EPO Plans: EPO $1,800 / $1,800 Option 2 / $2,600 / $3,350 / $3,750 / $4,300 / $4,500 / $6,000 / $6,800 / $7,500 / $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 | | | | | | | | | | | | | | |
| **HDHP EPO Plans: $3,500 (HSA) / $5,000 (HSA) / $6,500 (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.** | | | | | | | | | | | | | | |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plan | EPO $6,000 | | EPO $6,800 | | EPO $7,500 | | EPO $8,300 | | EPO $3,500 HDHP (HSA) | | EPO $5,000 HDHP (HSA) | | EPO $6,500 HDHP (HSA) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NETWORK** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** | **IN** | **OUT** |
| **In-network Provider:** Aetna EPO | | | | | | | | | | | | | | |
| **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 | $6,000 | Not Covered | $6,800 | Not Covered | $7,500 | Not Covered | $8,300 | Not Covered | $3,500 | Not Covered | $5,000 | Not Covered | $6,500 | Not Covered |
| • Family Unit* | $12,000 | | $13,600 | | $15,000 | | $16,600 | | $7,000 | | $10,000 | | $13,000 | |
| **Coinsurance** (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) | | | | | | | | | | | | | | |
| • Covered Person Pays | 20% | Not Covered | 25% | Not Covered | 20% | Not Covered | 25% | Not Covered | 20% | Not Covered | 20% | Not Covered | 25% | Not Covered |
| • Plan Pays | 80% | | 75% | | 80% | | 75% | | 80% | | 80% | | 75% | |
| **Out-of-Pocket Limit** (includes Deductible, Coinsurance and Copays) | | | | | | | | | | | | | | |
| • Individual | $10,000 | Not Covered | $9,200 | Not Covered | $10,000 | Not Covered | $9,200 | Not Covered | $8,300 | Not Covered | $8,300 | Not Covered | $8,300 | Not Covered |
| • Family Unit* | $20,000 | | $18,400 | | $20,000 | | $18,400 | | $16,600 | | $16,600 | | $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.

**EPO Plans: EPO $1,800 / $1,800 Option 2 / $2,600 / $3,350 / $3,750 / $4,300 / $4,500 / $6,000 / $6,800 / $7,500 / $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

**HDHP EPO Plans: $3,500 (HSA) / $5,000 (HSA) / $6,500 (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.**

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| 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** |
| **Covered Services - Illness or Injury** | | | | | | |
| **Physician Office Services**<br>• Primary Care Physician Office Visit<br>• Specialist Physician Office Visit<br>• Urgent Care Visit - 4 visits limit per benefit period. | $40 Copay<br>$70 Copay<br>$85 Copay | Not Covered | $40 Copay<br>$70 Copay<br>$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.<br>**Specialist Physician** is a physician who is not a Primary Care Physician.<br>**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.<br>**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.<br>**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.)<br>• Virtual Primary Care - Unlimited<br>• Urgent Care - Unlimited<br>• Mental Health (Triage) - 4 visits limit per benefit period. | $0 Copay, $0 Deductible through MyLiveDoc Telehealth platform<br>$40 Copay for all other Telehealth platforms | Not Covered | $0 Copay, $0 Deductible through MyLiveDoc Telehealth platform<br>$40 Copay for all other Telehealth platforms | Not Covered | $0 Copay, $0 Deductible through MyLiveDoc Telehealth platform<br>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)<br>• Facility<br>• 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 |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plan | EPO $1,800 Option 2 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500 | | EPO HDHP (HSA) $3,500 / $5,000 | |
|---|---|---|---|---|
| **NETWORK** | **IN** | **OUT** | **IN** | **OUT** |
| **Covered Services - Illness or Injury** | | | | |
| **Physician Office Services**<br>• Primary Care Physician Office Visit<br>• Specialist Physician Office Visit<br>• Urgent Care Visit | $25 Copay<br>$40 Copay<br>$60 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.<br>**Specialist Physician** is a physician who is not a Primary Care Physician.<br>**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.<br>**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.<br>**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.)<br>• Virtual Primary Care - 12 visits limit per benefit period.<br>• Urgent Care - Unlimited<br>• Mental Health (Triage) - 4 visits limit per benefit period. | $0 Copay, $0 Deductible through MyLiveDoc Telehealth platform<br>$25 Copay for all other Telehealth platforms | Not Covered | $0 Copay, $0 Deductible through MyLiveDoc Telehealth platform<br>Deductible and Coinsurance for all other Telehealth platforms | Not Covered |
| **NOTE:** Unlimited Urgent Care visits use for MyLiveDoc Telehealth Platform only. This does not include your physician's telemedicine services. Telemedicine used through your physician are considered visits and are included in the visit maximum per benefit period. | | | | |
| **Emergency Room Services** (services received in a hospital emergency room setting)<br>• Facility<br>• Professional Services | Deductible and Coinsurance | 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 |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| 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** |
| **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**<br>• Affordable Care Act (ACA) required preventive services (may by subject to limits that include, but are not limited to, age, gender, and frequency)<br>• ACA required covered preventive services (outside of limits)<br>• Other covered preventive services not required by ACA | Plan pays 100%<br>Same as any other illness<br>Same as any other illness | Not Covered | Plan pays 100%<br>Same as any other illness<br>Same as any other illness | Not Covered | Plan pays 100%<br>Same as any other illness<br>Same as any other illness | Not Covered |
| **Immunizations**<br>• Child<br>• 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 |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plan | EPO $1,800 Option 2 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500 | | EPO HDHP (HSA) $3,500 / $5,000 | |
|---|---|---|---|---|
| **NETWORK** | **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 |
| **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 |
| **Preventive Services** | | | | |
| **Preventive Care/ Screenings**<br>• Affordable Care Act (ACA) required preventive services (may by subject to limits that include, but are not limited to, age, gender, and frequency)<br>• ACA required covered preventive services (outside of limits)<br>• Other covered preventive services not required by ACA | Plan pays 100%<br>Same as any other illness<br>Same as any other illness | Not Covered | Plan pays 100%<br>Same as any other illness<br>Same as any other illness | Not Covered |
| **Immunizations**<br>• Child<br>• Adult | Plan pays 100% | Not Covered | Plan pays 100% | Not Covered |
| **Child Dentistry and Eye Care** | | | | |
| **Child Eye Exam** | As required by ACA | Not Covered | As required by ACA | Not Covered |
| **Child Glasses/ Contacts** | Not Covered | Not Covered | Not Covered | Not Covered |
| **Child Dental Check Up** | As required by ACA | Not Covered | As required by ACA | Not Covered |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| 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** |
| **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 |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plan | EPO $1,800 Options 2 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500 | | EPO HDHP (HSA) $3,500 / $5,000 | |
|---|---|---|---|---|
| **NETWORK** | **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 (30 Day Max per Benefit Period) | Not Covered | Deductible and Coinsurance (30 Day Max per Benefit Period) | Not Covered |
| **Outpatient Services** • Office Services | Deductible and Coinsurance (30 Day Max per Benefit Period) | Not Covered | Deductible and Coinsurance (30 Day Max per Benefit Period) | Not Covered |
| **Partial Hospitalization** | Not Covered | Not Covered | Not Covered | 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 • All Other Maternity Services | 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, MRS, PET and SPECT scans and other Nuclear Medicine) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| 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**<br>• Shots<br>• Visits/Testing | $40 Copay<br>$40 for Physician Visit / Deductible and Coinsurance for Testing | Not Covered | $40 Copay<br>$40 for Physician Visit / Deductible and Coinsurance for Testing | Not Covered | Deductible and Coinsurance | Not Covered |
| **Ambulance**<br>(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**<br>• Nutritional Counseling - 1 per Benefit Period.<br>• Supplies / Equipment | $40 Copay<br>$0 Copay w/DiaThrive | Not Covered | $40 Copay<br>$0 Copay w/DiaThrive | Not Covered | Deductible and Coinsurance<br>$0 Copay w/DiaThrive | Not Covered |
| **Diagnostic Test**<br>(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**<br>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)**<br>($500 Max per Benefit Period) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Home Health Care**<br>(limited to 8 visits per Benefit Period) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Hospice Services**<br>(limited to 32 hours per Benefit Period) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plan | EPO $1,800 Option 2 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500 | | EPO HDHP (HSA) $3,500 / $5,000 | |
|---|---|---|---|---|
| **NETWORK** | **IN** | **OUT** | **IN** | **OUT** |
| **Other Covered Services - Illness or Injury** (Continued 1 of 2) | | | | |
| **Allergies** (combined limit of 12 per benefit period).<br>• Shots<br>• Visits/Testing | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Ambulance** (to the nearest facility for appropriate care)<br>• Ground Ambulance<br>• Air Ambulance | Deductible and Coinsurance | Same as In-Network Benefit for Emergent Situations | Deductible and Coinsurance | Same as In-Network Benefit for Emergent Situations |
| **Diabetic Services**<br>• Nutritional Counseling<br>• Supplies / Equipment | $0 Copay w/MyLiveDoc Telehealth Platform<br>$0 Copay w/DiaThrive | Not Covered | $0 Copay w/MyLiveDoc Telehealth Platform<br>$0 Copay w/DiaThrive | Not Covered |
| **Diagnostic Test** (X-Ray, Lab, EKGs, ECGs, All other diagnostic services not included in Imaging) | $25 Copay for Lab / $100 Copay for X-Ray | Not Covered | Deductible and Coinsurance | Not Covered |
| **Dialysis** | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Durable Medical Equipment and Supplies (including Prosthetics)** (12 month rental or purchase, whichever is least costly). | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Home Health Care** (limited to 60 days per benefit period) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Hospice Services** (limited to 40 days per benefit period) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| 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 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)<br>• Mental Health, Behavioral Health, Substance Abuse Disorder Services<br>• Physical and occupational therapy Services.<br>• Speech therapy Services<br>• Spinal Manipulation Chiropractic treatments or adjustments.<br>• Cardiac rehabilitation<br>• 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 |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plan | EPO $1,800 Option 2 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500 | | EPO HDHP (HSA) $3,500 / $5,000 | |
|---|---|---|---|---|
| **NETWORK** | **IN** | **OUT** | **IN** | **OUT** |
| **Other Covered Services - Illness or Injury** (Continued 1 of 2) | | | | |
| **Infusion/Injection Drugs** | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Organ Transplants** | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Prosthetics and Orthotic** | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Radiation/Chemo** | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Rehabilitation, Therapy and Manipulation Services** (combined limit of 35 sessions per benefit period).<br>• Physical and occupational therapy Services.<br>• Speech therapy Services<br>• Spinal Manipulation Chiropractic treatments or adjustments.<br>• Cardiac rehabilitation<br>• Pulmonary rehabilitation | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **Skilled Nursing** (limited to 60 days per benefit period) | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |
| **All Other Covered Services** | Deductible and Coinsurance | Not Covered | Deductible and Coinsurance | Not Covered |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| 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 - October 31, 2026

| Major Medical Plan | EPO $1,800 Option 2 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500 | | EPO HDHP (HSA) $3,500 / $5,000 | |
|---|---|---|---|---|
| **NETWORK** | **IN** | **OUT** | **IN** | **OUT** |
| **Prescription Drugs** | | | | |
| **Retail - per 30 day supply** | | | | |
| • Preventive Medicine (Generic Only). | $0 copay | Not Covered* | Deductible and Coinsurance | Not Covered* |
| • Generic Drugs | $5 copay | Not Covered* | Deductible and Coinsurance | Not Covered* |
| • Preferred Brand and Non-preferred Name Drugs | Not Covered* | Not Covered* | Not Covered* | Not Covered* |
| • Specialty Drugs | Excluded* | Not Covered* | Excluded* | Not Covered* |
| **Mail Order - per 90 day supply** | | | | |
| • Generic Drugs (90-Day Supply) | $20 copay | Not Covered* | Deductible and Coinsurance | Not Covered* |
| • Preferred Brand and Non-preferred Name Drugs | Not Covered* | Not Covered* | Not Covered* | Not Covered* |
| • Specialty Drugs | Excluded* | Not Covered* | Excluded* | Not Covered* |
| **Diabetic Insulin** | | | | |
| • Generic Drugs | $0 copay | Not Covered* | Deductible and Coinsurance | Not Covered* |
| • Preferred Brand and Non-preferred Name Drugs | Not Covered* | Not Covered* | Not Covered* | Not Covered* |

**Pharmacy Benefit Manager: These plans utilize Kroger Health.**

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***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 - October 31, 2026

| Major Medical Plans · EPO / HSA · Monthly Contributions | | | | | | | |
|---|---|---|---|---|---|---|---|
| **PLAN** | **EPO $1,800** | **EPO $1,800 Option 2** | **EPO $2,600** | **EPO $3,350** | **EPO $3,750** | **EPO $4,300** | **EPO $4,500** |
| **AGES 18-29** | | | | | | | |
| Employee | $704.90 | $700.14 | $666.80 | $648.00 | $635.04 | $627.10 | $620.70 |
| Employee + Spouse | $1,191.38 | $1,183.33 | $1,126.98 | $1,095.22 | $1,084.05 | $1,080.99 | $1,069.96 |
| Employee + Child(ren) | $1,106.81 | $1,099.33 | $1,046.99 | $1,017.48 | $1,007.10 | $995.96 | $985.80 |
| Family | $1,685.67 | $1,674.28 | $1,594.55 | $1,549.61 | $1,533.81 | $1,539.77 | $1,524.06 |
| **AGES 30-44** | | | | | | | |
| Employee | $762.18 | $757.03 | $720.98 | $700.66 | $693.51 | $654.27 | $647.60 |
| Employee + Spouse | $1,332.10 | $1,323.10 | $1,260.10 | $1,224.59 | $1,212.09 | $1,132.60 | $1,121.05 |
| Employee + Child(ren) | $1,227.13 | $1,218.84 | $1,160.80 | $1,128.09 | $1,116.58 | $1,042.78 | $1,032.14 |
| Family | $1,812.88 | $1,800.63 | $1,714.89 | $1,666.56 | $1,649.56 | $1,615.90 | $1,599.42 |
| **AGES 45-54** | | | | | | | |
| Employee | $832.50 | $826.88 | $787.50 | $765.31 | $757.50 | $716.05 | $708.75 |
| Employee + Spouse | $1,425.42 | $1,415.78 | $1,348.37 | $1,310.37 | $1,297.00 | $1,241.82 | $1,229.16 |
| Employee + Child(ren) | $1,363.55 | $1,354.33 | $1,289.84 | $1,253.49 | $1,252.99 | $1,177.10 | $1,176.63 |
| Family | $1,975.27 | $1,961.92 | $1,868.49 | $1,815.84 | $1,797.31 | $1,772.83 | $1,754.75 |
| **AGES 55-64** | | | | | | | |
| Employee | $925.65 | $919.39 | $875.61 | $850.94 | $842.26 | $794.69 | $786.59 |
| Employee + Spouse | $1,586.00 | $1,575.28 | $1,500.27 | $1,457.99 | $1,443.11 | $1,395.19 | $1,380.96 |
| Employee + Child(ren) | $1,516.63 | $1,506.38 | $1,434.65 | $1,394.22 | $1,393.66 | $1,319.99 | $1,319.46 |
| Family | $2,273.55 | $2,258.18 | $2,150.65 | $2,090.04 | $2,089.20 | $2,041.22 | $2,040.40 |

# Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

Effective Date: November 1, 2025 - October 31, 2026

| Major Medical Plans · EPO / HSA · Monthly Contributions | | | | | | | |
|---|---|---|---|---|---|---|---|
| **PLAN** | **EPO $6,000** | **EPO $6,800** | **EPO $7,500** | **EPO $8,300** | **EPO $3,500 HDHP (HSA)** | **EPO $5,000 HDHP (HSA)** | **EPO $6,500 HDHP (HSA)** |
| **AGES 18-29** | | | | | | | |
| Employee | $588.11 | $552.82 | $535.45 | $524.74 | $634.07 | $592.93 | $581.07 |
| Employee + Spouse | $1,002.27 | $942.13 | $899.77 | $881.77 | $1,082.07 | $1,011.82 | $991.58 |
| Employee + Child(ren) | $925.21 | $869.70 | $832.59 | $815.94 | $1,005.27 | $940.00 | $921.20 |
| Family | $1,421.35 | $1,336.07 | $1,268.93 | $1,243.55 | $1,545.74 | $1,445.31 | $1,416.40 |
| **AGES 30-44** | | | | | | | |
| Employee | $613.05 | $576.27 | $557.56 | $546.41 | $665.62 | $626.02 | $613.50 |
| Employee + Spouse | $1,049.40 | $986.44 | $941.27 | $922.45 | $1,163.36 | $1,094.14 | $1,072.25 |
| Employee + Child(ren) | $968.00 | $909.92 | $870.31 | $852.90 | $1,071.68 | $1,007.92 | $987.76 |
| Family | $1,490.75 | $1,401.31 | $1,329.92 | $1,303.32 | $1,638.64 | $1,556.03 | $1,524.91 |
| **AGES 45-54** | | | | | | | |
| Employee | $676.94 | $636.33 | $622.34 | $609.89 | $742.35 | $712.88 | $698.62 |
| Employee + Spouse | $1,160.83 | $1,091.18 | $1,052.71 | $1,031.66 | $1,271.05 | $1,220.59 | $1,196.18 |
| Employee + Child(ren) | $1,102.41 | $1,036.27 | $1,002.03 | $981.99 | $1,215.89 | $1,167.62 | $1,144.27 |
| Family | $1,650.04 | $1,551.04 | $1,488.38 | $1,458.61 | $1,805.39 | $1,691.43 | $1,657.61 |
| **AGES 55-64** | | | | | | | |
| Employee | $756.42 | $711.03 | $701.04 | $687.02 | $842.43 | $784.38 | $768.69 |
| Employee + Spouse | $1,313.82 | $1,234.99 | $1,202.14 | $1,178.10 | $1,443.41 | $1,365.17 | $1,337.87 |
| Employee + Child(ren) | $1,245.22 | $1,170.51 | $1,141.82 | $1,118.98 | $1,380.28 | $1,285.17 | $1,259.47 |
| Family | $1,914.39 | $1,799.53 | $1,743.08 | $1,708.22 | $2,069.14 | $2,027.96 | $1,987.40 |

Population Science Management

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