Population Science Management

PLAN COMPARISON

Livelihood PPO Plans

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

July 1, 2025 - June 30, 2026

Major Medical Plan

600-1043-3

GIGCARE

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	PPO $1,800		PPO $2,600		PPO $3,350		PPO $4,300		PPO $6,000		PPO $7,500		PPO $3,500 HDHP (HSA)		PPO $5,000 HDHP (HSA)	
NETWORK	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
In-network Provider: Aetna PPO																
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. **PPO Plans: In some situations, Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.**																
Deductible (the amount the Covered Person pays each Benefit Period for Covered Services before the Coinsurance is payable)																
• Individual	$1,800	$3,600	$2,600	$5,200	$3,350	$6,700	$4,300	$8,600	$6,000	$12,000	$7,500	$15,000	$3,500	$7,000	$5,000	$10,000
• Family Unit*	$3,600	$7,200	$5,200	$10,400	$6,700	$13,400	$8,600	$17,200	$12,000	$24,000	$15,000	$30,000	$7,000	$14,000	$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	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
• Plan Pays	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%	80%	50%
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays)																
• Individual	$10,000	$20,000	$10,000	$20,000	$10,000	$20,000	$10,000	$20,000	$10,000	$20,000	$10,000	$20,000	$8,300	$16,600	$8,300	$16,600
• Family Unit*	$20,000	$40,000	$20,000	$40,000	$20,000	$40,000	$20,000	$40,000	$20,000	$40,000	$20,000	$40,000	$16,600	$33,200	$16,600	$33,200
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.																
PPO Plans: $3,350 / $4,300 / $6,000 / $7,500 **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 PPO Plans: $3,500 (HSA) / $5,000 (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

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Major Medical Plan	PPO $1,800 / $2,600 / $3,350 / $4,300 / $6,000 / $7,500		PPO HDHP (HSA) $3,500 / $5,000	
NETWORK	**IN**	**OUT**	**IN**	**OUT**
Covered Services - Illness or Injury				
Physician Office Services • Primary Care Physician Office Visit	$25 Copay	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Specialist Physician Office Visit	$40 Copay			
• Urgent Care Visit	$60 Copay			
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 - 12 visits limit per benefit period. • Urgent Care - Unlimited • Mental Health (Triage) - 4 visits limit per benefit period.	$0 Copay, $0 Deductible	Not Covered	$0 Copay, $0 Deductible	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) • Facility • 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

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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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
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)	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
• 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
Immunizations • Child • Adult	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Child Dentistry and Eye Care				
Child Eye Exam	As required by ACA	As required by ACA	As required by ACA	As required by ACA
Child Glasses/ Contacts	Not Covered	Not Covered	Not Covered	Not Covered
Child Dental Check Up	As required by ACA	As required by ACA	As required by ACA	As required by ACA

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NETWORK	**IN**	**OUT**	**IN**	**OUT**
Mental Health, Behavioral Health, and/or Substance Use Disorder Services				
Inpatient Services Paid at the facility's semi-private room rate.	Deductible and Coinsurance (30 Day Max per Benefit Period)	Deductible and Coinsurance (30 Day Max per Benefit Period)	Deductible and Coinsurance (30 Day Max per Benefit Period)	Deductible and Coinsurance (30 Day Max per Benefit Period)
Outpatient Services • Office Services	Deductible and Coinsurance (30 Day Max per Benefit Period)	Deductible and Coinsurance (30 Day Max per Benefit Period)	Deductible and Coinsurance (30 Day Max per Benefit Period)	Deductible and Coinsurance (30 Day Max per Benefit Period)
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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Allergies (combined limit of 12 per benefit period). • Shots • Visits/Testing	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

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NETWORK	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued 1 of 2)				
Diabetic Services • Nutritional Counseling • Supplies / Equipment	$0 Copay w/MyLiveDoc Telehealth Platform $0 Copay w/DiaThrive	Not Covered	$0 Copay w/MyLiveDoc Telehealth Platform $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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
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	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Home Health Care (limited to 60 days per benefit period)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services (limited to 40 days per benefit period)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Infusion/Injection Drugs	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Organ Transplants	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Prosthetics and Orthotic	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Radiation/Chemo	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered

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NETWORK	**IN**	**OUT**	**IN**	**OUT**
Other Covered Services - Illness or Injury (Continued 2 of 2)				
Rehabilitation, Therapy and Manipulation Services (combined limit of 35 sessions per benefit period). • Physical and occupational therapy Services. • Speech therapy Services • Spinal Manipulation Chiropractic treatments or adjustments. • Cardiac rehabilitation • Pulmonary rehabilitation	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Skilled Nursing (limited to 60 days per benefit period)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

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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.

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 welcome 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

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

Major Medical Plans · PPO / HSA · Monthly Contributions								
PLAN	**PPO $1,800**	**PPO $2,600**	**PPO $3,350**	**PPO $4,300**	**PPO $6,000**	**PPO $7,500**	**PPO $3,500 (HSA)**	**PPO $5,000 (HSA)**
AGES 18-29								
Employee	$721.14	$686.80	$667.44	$645.91	$605.75	$551.52	$653.09	$610.72
Employee + Spouse	$1,218.83	$1,160.79	$1,128.07	$1,113.42	$1,032.34	$926.76	$1,114.53	$1,042.17
Employee + Child(ren)	$1,132.31	$1,078.39	$1,048.00	$1,025.84	$952.97	$857.57	$1,035.43	$968.20
Family	$1,724.51	$1,642.39	$1,596.10	$1,585.96	$1,463.99	$1,307.00	$1,592.11	$1,488.67
AGES 30-44								
Employee	$779.74	$742.61	$721.68	$673.90	$631.44	$574.29	$685.59	$644.80
Employee + Spouse	$1,362.80	$1,297.90	$1,261.32	$1,166.58	$1,080.88	$969.51	$1,198.26	$1,126.96
Employee + Child(ren)	$1,255.40	$1,195.62	$1,161.93	$1,074.06	$997.04	$896.42	$1,103.83	$1,038.15
Family	$1,854.65	$1,766.33	$1,716.55	$1,664.38	$1,535.48	$1,369.81	$1,687.80	$1,602.71
AGES 45-54								
Employee	$851.69	$811.13	$788.27	$737.53	$697.25	$641.01	$764.62	$734.27
Employee + Spouse	$1,458.26	$1,388.82	$1,349.68	$1,279.08	$1,195.66	$1,084.30	$1,309.19	$1,257.21
Employee + Child(ren)	$1,394.96	$1,328.54	$1,291.09	$1,212.41	$1,135.48	$1,032.09	$1,252.37	$1,202.65
Family	$2,020.78	$1,924.55	$1,870.31	$1,826.01	$1,699.54	$1,533.03	$1,859.55	$1,742.18
AGES 55-64								
Employee	$946.97	$901.88	$876.46	$818.53	$779.11	$722.07	$867.70	$807.91
Employee + Spouse	$1,622.54	$1,545.27	$1,501.72	$1,437.05	$1,353.23	$1,238.21	$1,486.71	$1,406.13
Employee + Child(ren)	$1,551.58	$1,477.69	$1,436.05	$1,359.59	$1,282.58	$1,176.07	$1,421.69	$1,323.73
Family	$2,325.93	$2,215.17	$2,152.74	$2,102.46	$1,971.82	$1,795.37	$2,131.21	$2,088.80

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GIGCARE