



GIGCARE

HEALTH BENEFITS HIGHLIGHTS



Scan Me

OUR VALUE PROPOSITION

WHAT WE OFFER

at Population Science Management

Controlled and Predictable Costs

- Competitive pricing.
- Lower monthly out-of-pocket expenses.

Full Suite of Networks and Complimentary Services

- An array of plans to suit your deductible needs for any budget.
- Nationwide access to 2 million+ physicians and ancillary providers.
- A complete network of benefits partners.
- Live daytime customer service.
- 24/7 access to Member Portal services.

HOW WE'RE ABLE TO OFFER IT

Flexibility in Plans, Programs and Costs

- We provide access to our GigCare Health Plans in return for your data.
- Preauthorization and Care Management programs included.
- No primary care physician or referrals required.

PLAN OVERVIEW

Network

- Cigna PPO
- Aetna EPO

Plan Qualifications

- 4 Age Bands: 18-29, 30-44, 45-54, and 55-64
- Working Owner status

PPO & EPO Plan Types

- GigCare EPO Plans: Deductibles of \$1800, \$3750, \$4500, \$6800, \$8300, and HSA's with deductibles of \$3500 and \$5000
- GigCare PPO Plans: Deductible of \$1800, \$2600, \$3350, \$4300, \$600, \$7500, and HSA's with deductibles of \$3500 and \$5000

Pharmacy

- Kroger Health

Rates

- Affordable monthly rates, contact Jeff Walstrom today!

SERVICES



Concierge Services

GigCare has Care Guides available at (866) 200-2513 from 7:30AM - 6PM CST to support your every need.



Member Portal

When you are logged on, you can access your ID cards, download forms, access your plan documents and much more!



Pharmaceutical Advocacy Services

ScriptAide provides pharmaceutical advocacy services, reducing the financial burden. Our direct-to-member support services are staffed by Pharmaceutical Access Coordinators specialized in helping acquire prescribed medications that may not be covered by your health plan.



OUR PARTNERS



Telemedicine: 24/7 access to primary care, urgent care, and mental health care!



Diabetic Solutions: Diathrive makes sure you're getting the best diabetic care.



Affordable Medical Imaging: Make the most informed decision about MRIs, CTs and other imaging procedures.



Third-Party Administrator: Detego Health, LLC® acts as an advocate, working to limit the costs of healthcare without sacrificing quality or access to care.

CONTACT: 913-799-8199

VISIT: kcrar.kauffmaninsurancegroup.com/home-145467

600-1004-6



Population Science Management

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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)



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)	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
In-network Provider: Aetna												
Payment for Services												
<p>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.</p> <p>EPO Plans: There is no Out-of-Network coverage under these Plans.</p>												
Deductible (the amount the Covered Person pays each Benefit Period for Covered Services before the Coinsurance is payable) • Individual • Family Unit*	\$1,800 \$3,600	Not Covered	\$3,750 \$7,500	Not Covered	\$4,500 \$9,000	Not Covered	\$6,800 \$13,600	Not Covered	\$8,300 \$16,600	Not Covered	\$6,500 \$13,000	Not Covered
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays • Plan Pays	25% 75%	Not Covered	25% 75%	Not Covered	25% 75%	Not Covered	25% 75%	Not Covered	25% 75%	Not Covered	25% 75%	Not Covered
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays) • Individual • Family Unit*	\$9,200 \$18,400	Not Covered	\$9,200 \$18,400	Not Covered	\$9,200 \$18,400	Not Covered	\$9,200 \$18,400	Not Covered	\$9,200 \$18,400	Not Covered	\$8,300 \$16,600	Not Covered
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: <ul style="list-style-type: none"> <li style="width: 25%;">• Physician Office <li style="width: 25%;">• Physical, Occupational and Speech Therapy Services <li style="width: 25%;">• Manipulations <li style="width: 25%;">• Mental Health/Substance Abuse/Autism Outpatient & Office <li style="width: 25%;">• Specialist Office <li style="width: 25%;">• Cardiac Rehabilitation <li style="width: 25%;">• Routine Vision Exam <li style="width: 25%;">• Prescription Drugs <li style="width: 25%;">• Urgent Care Facility 												
Plan: EPO \$6,500 HDHP (HSA) Copayment(s) (copay(s)) apply to: <ul style="list-style-type: none"> • 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

Major Medical Plan	EPO \$1,800 / \$3,750		EPO \$4,500 / \$6,800 / \$8,300		EPO HDHP (HSA) \$6,500	
	IN	OUT	IN	OUT	IN	OUT
Covered Services - Illness or Injury						
Physician Office Services <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Urgent Care Visit - 4 visits limit per benefit period. 	\$40 Copay	Not Covered	\$40 Copay	Not Covered	Deductible and Coinsurance	Not Covered
<p>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.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>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.</p> <p>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.</p> <p>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.</p>						
Telehealth/Virtual Care Services (through MyLiveDoc telehealth platform.) <ul style="list-style-type: none"> Virtual Primary Care - Unlimited Urgent Care - Unlimited Mental Health (Triage) - 4 visits limit per benefit period. 	\$0 Copay, \$0 Deductible through MyLiveDoc Telehealth platform	Not Covered	\$0 Copay, \$0 Deductible through MyLiveDoc Telehealth platform	Not Covered	\$0 Copay, \$0 Deductible through MyLiveDoc Telehealth platform	Not Covered
<p>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.</p>						
Emergency Room Services (services received in a hospital emergency room setting) <ul style="list-style-type: none"> 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

Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

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	
	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 <ul style="list-style-type: none"> Affordable Care Act (ACA) required preventive services (may be 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%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
	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		Same as any other illness	
Immunizations <ul style="list-style-type: none"> 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

Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

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
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
<p>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.</p> <p>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.</p>						
Pregnancy / Maternity						
Pregnancy and Maternity (Dependent daughter pregnancy is not covered.) • Routine Vaginal Delivery • Routine C-Section Delivery • Inpatient Facility • Professional Services • Prenatal/Postnatal Office Visits • All Other Maternity Services • NICU - Up to 5 Days	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance Deductible and \$2,500 Copay	Not Covered	Deductible and Coinsurance	Not Covered
<p>NOTE: The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.</p>						
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

Major Medical Plan	EPO \$1,800 / \$3,750		EPO \$4,500 / \$6,800 / \$8,300		EPO HDHP (HSA) \$6,500	
	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/Physician 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

Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

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	
	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) <ul style="list-style-type: none"> • 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

Summary of Benefits & Coverage: Livelihood Plan Comparison

Group Name: Population Science Management

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

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

PLAN COMPARISON SUMMARY

PPO Plans:

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

EPO Plans:

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



Major Medical Plan

Effective Date: 07/01/2025

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

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)	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
In-network Provider: Cigna																
Payment for Services																
<p>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.</p> <p>PPO Plans: In some situations, Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.</p> <p>EPO Plans: There is no Out-of-Network coverage under these Plans.</p>																
Deductible (the amount the Covered Person pays each Benefit Period for Covered Services before the Coinsurance is payable)																
<ul style="list-style-type: none"> Individual Family Unit* 	\$1,800 \$3,600	\$3,600 \$7,200	\$2,600 \$5,200	\$5,200 \$10,400	\$3,350 \$6,700	\$6,700 \$13,400	\$4,300 \$8,600	\$8,600 \$17,200	\$6,000 \$12,000	\$12,000 \$24,000	\$7,500 \$15,000	\$15,000 \$30,000	\$3,500 \$7,000	\$7,000 \$14,000	\$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)																
<ul style="list-style-type: none"> Covered Person Pays Plan Pays 	20% 80%	50% 50%	20% 80%	50% 50%	20% 80%	50% 50%	20% 80%	50% 50%	20% 80%	50% 50%	20% 80%	50% 50%	20% 80%	50% 50%	20% 80%	50% 50%
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays)																
<ul style="list-style-type: none"> Individual Family Unit* 	\$10,000 \$20,000	\$20,000 \$40,000	\$10,000 \$20,000	\$20,000 \$40,000	\$10,000 \$20,000	\$20,000 \$40,000	\$10,000 \$20,000	\$20,000 \$40,000	\$10,000 \$20,000	\$20,000 \$40,000	\$10,000 \$20,000	\$20,000 \$40,000	\$8,300 \$16,600	\$16,600 \$33,200	\$8,300 \$16,600	\$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.																
Plans: PPO \$3,350, PPO \$4,300, PPO \$6,000, PPO \$7,500																
Copayment(s) (copay(s)) apply to: <ul style="list-style-type: none"> 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: PPO \$3,500 HDHP (HSA), PPO \$5,000 HDHP (HSA)																
Copayment(s) (copay(s)) apply to: <ul style="list-style-type: none"> 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: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800		EPO \$2,600		EPO \$3,350		EPO \$4,300		EPO \$6,000		EPO \$7,500		EPO \$3,500 HDHP (HSA)		EPO \$5,000 HDHP (HSA)	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
NETWORK																
In-network Provider: Cigna																
Payment for Services																
<p>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.</p> <p>PPO Plans: In some situations, Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.</p> <p>EPO Plans: There is no Out-of-Network coverage under these Plans.</p>																
Deductible (the amount the Covered Person pays each Benefit Period for Covered Services before the Coinsurance is payable)																
<ul style="list-style-type: none"> Individual Family Unit* 	\$1,800	Not Covered	\$2,600	Not Covered	\$3,350	Not Covered	\$4,300	Not Covered	\$6,000	Not Covered	\$7,500	Not Covered	\$3,500	Not Covered	\$5,000	Not Covered
	\$3,600		\$5,200		\$6,700		\$8,600		\$12,000		\$15,000		\$7,000		\$10,000	
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)																
<ul style="list-style-type: none"> Covered Person Pays Plan Pays 	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered
	80%		80%		80%		80%		80%		80%		80%		80%	
Out-of-Pocket Limit (includes Deductible, Coinsurance and Copays)																
<ul style="list-style-type: none"> Individual Family Unit* 	\$10,000	Not Covered	\$10,000	Not Covered	\$10,000	Not Covered	\$10,000	Not Covered	\$10,000	Not Covered	\$10,000	Not Covered	\$8,000	Not Covered	\$8,000	Not Covered
	\$20,000		\$20,000		\$20,000		\$20,000		\$20,000		\$20,000		\$16,000		\$16,000	
<p>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.</p>																
<p>*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.</p>																
Copays Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.																
<p>Plans: EPO \$3,350, EPO \$4,300, EPO \$6,000, EPO \$7,500</p> <p>Copayment(s) (copay(s)) apply to:</p> <ul style="list-style-type: none"> 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 																
<p>Plan: EPO \$3,500 HDHP (HSA), EPO \$5,000 HDHP (HSA)</p> <p>Copayment(s) (copay(s)) apply to:</p> <ul style="list-style-type: none"> This plan has no medical or prescription copays <p>The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.</p>																
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: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

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 <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Urgent Care Visit 	\$25 Copay \$40 Copay \$60 Copay	 Deductible and Coinsurance 	 Deductible and Coinsurance 	 Deductible and Coinsurance
<p>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.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>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.</p> <p>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.</p> <p>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.</p>				
Telehealth/Virtual Care Services (through MyLiveDoc telehealth platform.) <ul style="list-style-type: none"> 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
<p>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.</p>				
Emergency Room Services (services received in a hospital emergency room setting) <ul style="list-style-type: none"> 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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		EPO HDHP (HSA) \$3,500 / \$5,000	
	NETWORK	IN	OUT	IN
Covered Services - Illness or Injury				
Physician Office Services <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Urgent Care Visit 	\$25 Copay \$40 Copay \$60 Copay	 Not Covered 	 Deductible and Coinsurance 	 Not Covered
<p>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.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>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.</p> <p>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.</p> <p>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.</p>				
Telehealth/Virtual Care Services (through MyLiveDoc telehealth platform.) <ul style="list-style-type: none"> 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 through MyLiveDoc Telehealth platform \$25 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
<p>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.</p>				
Emergency Room Services (services received in a hospital emergency room setting) <ul style="list-style-type: none"> 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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	PPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		PPO HDHP (HSA) \$3,500 / \$5,000	
	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 <ul style="list-style-type: none"> Affordable Care Act (ACA) required preventive services (may be 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	Plan pays 100% Same as any other illness Same as any other illness	Plan pays 100% Same as any other illness Same as any other illness	Plan pays 100% Same as any other illness Same as any other illness
Immunizations <ul style="list-style-type: none"> 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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		EPO HDHP (HSA) \$3,500 / \$5,000	
	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 <ul style="list-style-type: none"> Affordable Care Act (ACA) required preventive services (may be 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
Immunizations <ul style="list-style-type: none"> Child 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: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

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
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
<p>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.</p> <p>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.</p>				
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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800 / \$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
<p>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.</p> <p>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.</p>				
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
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	Same as In-Network Benefit for Emergent Situations	Deductible and Coinsurance	Same as In-Network Benefit for Emergent Situations

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

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
Other Covered Services - Illness or Injury (Continued 1 of 2)					
Diabetic Services					
• Nutritional Counseling	\$0 Copay w/MyLiveDoc Telehealth Platform	Not Covered	\$0 Copay w/MyLiveDoc Telehealth Platform	Not Covered	
• Supplies / Equipment	\$0 Copay w/DiaThrive		\$0 Copay w/DiaThrive		
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	

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		EPO HDHP (HSA) \$3,500 / \$5,000	
	IN	OUT	IN	OUT
Other Covered Services - Illness or Injury (Continued 1 of 2)				
Diabetic Services				
• Nutritional Counseling	\$0 Copay w/MyLiveDoc Telehealth Platform	Not Covered	\$0 Copay w/MyLiveDoc Telehealth Platform	Not Covered
• Supplies / Equipment	\$0 Copay w/DiaThrive		\$0 Copay w/DiaThrive	
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
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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	PPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		PPO HDHP (HSA) \$3,500 / \$5,000	
	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). <ul style="list-style-type: none"> 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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		EPO HDHP (HSA) \$3,500 / \$5,000	
	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). <ul style="list-style-type: none"> Physical and occupational therapy Services. Speech therapy Services Spinal Manipulation Chiropractic treatments or adjustments. Cardiac rehabilitation 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: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	PPO		PPO HDHP (HSA)	
	\$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		\$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.

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: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

Major Medical Plan	EPO \$1,800 / \$2,600 / \$3,350 / \$4,300 / \$6,000 / \$7,500		EPO HDHP (HSA) \$3,500 / \$5,000	
	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).

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Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

Effective Date: July 1, 2025

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

Summary of Benefits & Coverage: Intelligent Plan Comparison

Group Name: Intellihealth

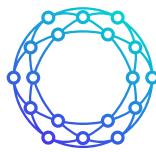
Effective Date: July 1, 2025

Major Medical Plans - EPO / HSA - Monthly Contributions								
PLAN	EPO \$1,800	EPO \$2,600	EPO \$3,350	EPO \$4,300	EPO \$6,000	EPO \$7,500	EPO \$3,500 (HSA)	EPO \$5,000 (HSA)
AGES 18-29								
Employee	\$700.14	\$666.80	\$648.00	\$627.10	\$588.11	\$535.45	\$634.07	\$592.93
Employee + Spouse	\$1,183.33	\$1,126.98	\$1,095.22	\$1,080.99	\$1,002.27	\$899.77	\$1,082.07	\$1,011.82
Employee + Child(ren)	\$1,099.33	\$1,046.99	\$1,017.48	\$995.96	\$925.21	\$832.59	\$1,005.27	\$940.00
Family	\$1,674.28	\$1,594.55	\$1,549.61	\$1,539.77	\$1,421.35	\$1,268.93	\$1,545.74	\$1,445.31
AGES 30-44								
Employee	\$757.03	\$720.98	\$700.66	\$654.27	\$613.05	\$557.56	\$665.62	\$626.02
Employee + Spouse	\$1,323.10	\$1,260.10	\$1,224.59	\$1,132.60	\$1,049.40	\$941.27	\$1,163.36	\$1,094.14
Employee + Child(ren)	\$1,218.84	\$1,160.80	\$1,128.09	\$1,042.78	\$968.00	\$870.31	\$1,071.68	\$1,007.92
Family	\$1,800.63	\$1,714.89	\$1,666.56	\$1,615.90	\$1,490.75	\$1,329.92	\$1,638.64	\$1,556.03
AGES 45-54								
Employee	\$826.88	\$787.50	\$765.31	\$716.05	\$676.94	\$622.34	\$742.35	\$712.88
Employee + Spouse	\$1,415.78	\$1,348.37	\$1,310.37	\$1,241.82	\$1,160.83	\$1,052.71	\$1,271.05	\$1,220.59
Employee + Child(ren)	\$1,354.33	\$1,289.84	\$1,253.49	\$1,177.10	\$1,102.41	\$1,002.03	\$1,215.89	\$1,167.62
Family	\$1,961.92	\$1,868.49	\$1,815.84	\$1,772.83	\$1,650.04	\$1,488.38	\$1,805.39	\$1,691.43
AGES 55-64								
Employee	\$919.39	\$875.61	\$850.94	\$794.69	\$756.42	\$701.04	\$842.43	\$784.38
Employee + Spouse	\$1,575.28	\$1,500.27	\$1,457.99	\$1,395.19	\$1,313.82	\$1,202.14	\$1,443.41	\$1,365.17
Employee + Child(ren)	\$1,506.38	\$1,434.65	\$1,394.22	\$1,319.99	\$1,245.22	\$1,141.82	\$1,380.28	\$1,285.17
Family	\$2,258.18	\$2,150.65	\$2,090.04	\$2,041.22	\$1,914.39	\$1,743.08	\$2,069.14	\$2,027.96

Notes

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



Population Science
Management