

| DESCRIPTION OF BENEFITS | | | | | |
|--|-------|--|---|--|----------------|
| PLAN PROVISIONS | | Member Pays | | | |
| | | Care Advocate | In-Network | Out-of-Network | |
| Annual Deductible (Includes Medical and Pharmacy) | | None | \$4,000 Per Person \$8,000 Per Family | \$8,000 Per Person \$16,000 Per Family | |
| Annual Out of Pocket Maximum (Includes Medical and Pharmacy) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum. | | None | \$7,050 Per Person \$14,100 Per Family | Unlimited | |
| Amounts in Excess of Negotiated Rates/Maximum Allowable Charges | | Not Applicable | For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate. The Member will be responsible for the Deductible, Copayments, and Coinsurance. | For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Maximum Allowable Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Maximum Allowable Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum. | |
| Lifetime Maximum | | None | | | |
| Dependent Coverage | | To age 26 | | | |
| <p>Care Advocate tier option with no out-of-pocket cost may be available if Verdegard + Advanta is notified 5 business days or more prior to the service date, however we can not guarantee a Care Advocate option will be available. Verdegard + Advanta will attempt a no out of pocket cost for notifications with less than 5 business days, but a Care Advocate option may not be available.</p> | | | | | |
| MEDICAL SERVICES <i>All plan benefits shown as a percentage of Eligible Charge</i> | | Do Services Require Prior Authorization? | Member Pays | | |
| PHYSICIAN SERVICES | | | Care Advocate | In-Network | Out-of-Network |
| Primary Care Office Visits | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge | |
| Specialist Care Office Visits | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge | |
| Other Services performed in the office (Including Diagnostic Services, Office Surgery and Radiology Services, Laboratory and Pathology (Prior Authorization rules for any other service performed in the office, please refer to the Diagnostic Services section)). | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge | |
| Physician Services in a Facility (Hospital, Outpatient Surgery) | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge | |
| Physician Services in a Facility (Emergency Room) | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge | |
| Urgent Care | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge | |

| | Do Services Require Prior Authorization? | Member Pays | | |
|---|--|----------------|---|---|
| | | Care Advocate | In-Network | Out-of-Network |
| MATERNITY CARE | | | | |
| Physician Services | No (Unless stay exceeds 48 hours (vaginal delivery) or 96 hours (c-section delivery)**) | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| PREVENTIVE CARE | | | | |
| Benefits for Children | | | | |
| Newborn Circumcision | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Child Care Office Visits 0 to 11 months (6 “well-baby visits”) 1 to 4 years (7 “well-child visits”) 5 to 17 years (1 per year, “well-child visit”) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Child Care Immunizations (As recommended by Bright Futures Project) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Child Care Lab Tests (As recommended by Bright Futures Project) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Adult Preventive Screening/Testing | | | | |
| Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Immunization Services for Adults Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Prostate Specific Antigen (Men, one per CY, age ≥ 50) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Colorectal cancer screening for adults of certain ages or at higher risk (Covered in a non-Hospital setting only unless medically necessary) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Abdominal Aortic Aneurysm one-time screening for men of certain ages who have ever smoked (Covered in non-Hospital setting only) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Lung cancer screening for adults of certain ages at increased risk. (Covered in a non-Hospital setting only) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Screenings such as; Obesity, Blood Pressure, Cholesterol, HIV, Alcohol Misuse | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

| | Do Services Require Prior Authorization? | Member Pays | | |
|---|--|---------------------------------|---|---|
| | | Care Advocate | In-Network | Out-of-Network |
| PREVENTIVE CARE | | | | |
| Benefits for Women | | | | |
| Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables). (Pharmacy - birth control pills, diaphragms, emergency contraceptive pill through your Pharmacy Benefits) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all limitations as described under Covered Medical Benefits) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all limitations as described under Covered Medical Benefits) | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening. Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. (Reimbursement of Non-Participating breastfeeding supplies up to the amount of \$200). | No | Not Applicable | Covered in Full | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| HOSPITAL/FACILITY SERVICES | | | | |
| Inpatient Room & Care – semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Outpatient / Ambulatory Surgery Services & Birthing Centers | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST) | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Transplant Procedures | Yes** | \$0 Copayment / 0% Coinsurance* | \$3,050 Copayment after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Spinal Fusion Surgery | Yes** | \$0 Copayment / 0% Coinsurance* | \$3,050 Copayment after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Planned Cardiovascular Procedures | Yes** | \$0 Copayment / 0% Coinsurance* | \$3,050 Copayment after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Emergency Room Services | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

| | Do Services Require Prior Authorization? | Member Pays | | |
|---|--|---------------------------------|---|---|
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| DIAGNOSTIC SERVICES | | | | |
| Laboratory Services | | | | |
| Non-Hospital Based | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Radiology Services | | | | |
| Non-Hospital Based | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Radiation Oncology Services | | | | |
| Non-Hospital Based | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| CT/MRI/MRA/PET Scan | | | | |
| Non-Hospital Based | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER | | | | |
| Inpatient | | | | |
| Hospital & Facility Services; Semi-private room rate | Yes** | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Psychiatrist & Psychologist Services | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Outpatient | | | | |
| Psychiatrist & Psychologist Services | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Psychological Testing | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

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|---|--|---------------------------------|---|---|
| | | Care Advocate | In-Network | Out-of-Network |
| OTHER SERVICES | | | | |
| Allergy Testing (Including serums, injections, and administration) | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Ambulance – Emergent (Ground) | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Ambulance – Emergent (Air) | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Ambulance – Non-Emergent (Ground) | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Ambulance – Non-Emergent (Air) | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Chemotherapy | Yes** | \$0 Copayment / 0% Coinsurance* | \$3,050 Copayment after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Dialysis and Supplies | Yes** | Not Applicable | \$3,050 Copayment after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Durable Medical Equipment (Including Orthotics/Prosthetics) | Yes** (If greater than \$500 charge per single item) | \$0 Copayment / 0% Coinsurance* | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Enteral Nutrition Therapy | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hearing Aids (Limited to (1) device per ear every five (5) years) Maximum of \$1,500 per covered device | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Evaluations for the Use of Hearing Aids | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Home Health Services (Maximum of 120 visits per year) | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Home Infusion Services | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospice Services | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Human Growth Hormone, Genetic Testing/Counseling, Other | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Physical/Occupational/Speech Therapy (Non-Hospital Based) | Yes** | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

| | Do Services Require Prior Authorization? | Member Pays | | |
|--|--|----------------|---|---|
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| ALTERNATIVE CARE SERVICES There is a combined benefit year maximum of \$400.00 paid by the Plan for Alternative Care Services. | | | | |
| Acupuncture | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Chiropractic Care | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Naturopathy | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Massage Therapy | No | Not Applicable | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

* Cannot guarantee a "Care Advocate" option will be available in your area for every medical service or procedure in this category. Some travel may be necessary to receive \$0 Copay for larger cost non-emergent procedures.

** No benefit if Prior Authorization is not provided. Prior Authorization must be obtained in order to be a covered benefit.

When utilizing the Care Advocate tier level of benefits, the minimum IRS deductible must be satisfied before member cost-sharing is waived. The minimum IRS deductible amount will be applied to the In-Network Annual Medical Deductible.

Coinsurance amount is based on an approved negotiated rate for Participating Providers or the Maximum Allowable Charge reimbursement level for Non-Participating Providers as established by the Plan.

Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements.

Benefits that are determined to be emergent services or services that are subject to the No Surprises Act will be reimbursed at the Participating Provider level of benefits.

The Plan reserves the right to audit all claims to ensure appropriate billing and medical appropriateness for all services provided.

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions, and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

DESCRIPTION OF BENEFITS

| PHARMACY PROVISIONS (Please refer to Member ID Card for Pharmacy Benefit Information) | Member Pays | | |
|---|----------------------|---|----------------------------------|
| | Care Advocate | In-Network Pharmacies | Out-of-Network Pharmacies |
| Annual Deductible | None | Combined with the Medical Annual Deductible | Not Applicable |
| Annual Out of Pocket Maximum | None | Combined with the Medical Out of Pocket Maximum | Not Applicable |
| Lifetime Maximum | None | | |
| PREVENTIVE PRESCRIPTION SERVICES | | | |
| Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. | | | |
| In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs. | | | |
| Prescription Drugs Pharmacy Retail - up to a 30-Day Supply | Not Applicable | Generic - \$0 Copayment | Not Covered |
| NON-PREVENTIVE PRESCRIPTION SERVICES | | | |
| All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician. All specialty drugs and certain non-specialty drug categories are mandated to process through the mail order pharmacy or specialty program including, but not limited to: diabetic supplies and insulins, behavioral health, HIV, transplant and anticoagulant drugs. These drugs are only allowed to process through the mail order pharmacy or specialty pharmacy as applicable. | | | |
| Prescription Drugs Pharmacy Retail - up to a 30-Day supply | Not Applicable | Generic / Brand / Non-Preferred Brand – 20% Coinsurance after Annual Deductible | Not Covered |
| Prescription Drugs Pharmacy Retail – 90-Day Supply | Not Applicable | Generic / Brand / Non-Preferred Brand – 20% Coinsurance after Annual Deductible | Not Covered |
| Prescription Drugs Pharmacy Mail Order – 90-Day Supply | Not Applicable | Generic / Brand / Non-Preferred Brand – 20% Coinsurance after Annual Deductible | Not Covered |
| Specialty Drugs | Not Applicable | 20% Coinsurance after Annual Deductible | Not Covered |
| This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence. | | | |

All plans are administered by Verdegard Administrators, LLC, a licensed third-party administrator located at 8060 S. Kyrene Road, Suite #100, Tempe, AZ 85284. Products and services are not available in all states. All plans are self-funded, meaning that the employer group is responsible for funding the plan and claim costs up to applicable stop-loss limits.