

| DESCRIPTION OF BENEFITS                                                                                                                                                                                                                                             |                                                                                                                                     |                                         |                                                                                                                                                                                                                                                                                                                                                                          |
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| PLAN PROVISIONS                                                                                                                                                                                                                                                     | In-Network                                                                                                                          |                                         | Out-of-Network                                                                                                                                                                                                                                                                                                                                                           |
| Annual Medical Deductible                                                                                                                                                                                                                                           | \$1,000 Per Person<br>\$3,000 Per Family                                                                                            |                                         | \$2,000 Per Person<br>\$6,000 Per Family                                                                                                                                                                                                                                                                                                                                 |
| Annual Out of Pocket Maximum (includes Medical and Pharmacy)<br>The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.                                                                                                     | \$8,700 Per Person<br>\$17,400 Per Family                                                                                           |                                         | \$17,400 Per Person<br>Maximum \$34,800 Per Family                                                                                                                                                                                                                                                                                                                       |
| Amounts in Excess of Negotiated Rates/Maximum Allowable Charges                                                                                                                                                                                                     | For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate. |                                         | 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                                                                                                                           |                                         |                                                                                                                                                                                                                                                                                                                                                                          |
| <b>MEDICAL SERVICES</b><br><i>All plan benefits shown as a percentage of Eligible Charge</i>                                                                                                                                                                        | <b>Do Services Require Prior Authorization?</b>                                                                                     | <b>Member Pays</b>                      |                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                     |                                                                                                                                     | <b>In-Network</b>                       | <b>Out-of-Network</b>                                                                                                                                                                                                                                                                                                                                                    |
| <b>PHYSICIAN SERVICES</b>                                                                                                                                                                                                                                           |                                                                                                                                     |                                         |                                                                                                                                                                                                                                                                                                                                                                          |
| Primary Care Office Visits                                                                                                                                                                                                                                          | No                                                                                                                                  | \$35 Copayment per visit                | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge                                                                                                                                                                                                                                                                            |
| Specialist Care Office Visits                                                                                                                                                                                                                                       | No                                                                                                                                  | \$35 Copayment per visit                | 40% 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                                                                                                                                  | 20% Coinsurance after Annual Deductible | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge                                                                                                                                                                                                                                                                            |
| Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)                                                                                                                                                                                     | No                                                                                                                                  | 20% Coinsurance after Annual Deductible | 20% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge                                                                                                                                                                                                                                                                            |
| Urgent Care                                                                                                                                                                                                                                                         | No                                                                                                                                  | \$75 Copayment per visit                | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge                                                                                                                                                                                                                                                                            |

| <b>MEDICAL SERVICES</b><br><i>All plan benefits shown as a percentage of Eligible Charge</i>                                                                                                      | <b>Do Services<br/>Require Prior<br/>Authorization?</b> | <b>Member Pays</b>                      |                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                   |                                                         | <b>In-Network</b>                       | <b>Out-of-Network</b>                                                                         |
| <b>MATERNITY SERVICES</b>                                                                                                                                                                         |                                                         |                                         |                                                                                               |
| Physician Services                                                                                                                                                                                | No                                                      | 20% Coinsurance after Annual Deductible | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| <b>PREVENTIVE SERVICES</b>                                                                                                                                                                        |                                                         |                                         |                                                                                               |
| <b>Benefits For Children</b>                                                                                                                                                                      |                                                         |                                         |                                                                                               |
| Newborn Circumcision                                                                                                                                                                              | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Child Care Office Visits<br>0 to 11 months (6 “well-baby visits”)<br>1 to 4 years (7 “well-child visits”)<br>5 to 17 years (1 per year, “well-child visit”)                                  | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Child Care Immunizations<br>(As recommended by Bright Futures Project)                                                                                                                       | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Well Child Care Lab Tests<br>(As recommended by Bright Futures Project)                                                                                                                           | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| <b>Adult Preventive Screening/Testing</b>                                                                                                                                                         |                                                         |                                         |                                                                                               |
| Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services                                                                                           | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Immunization Services for Adults<br>Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP) | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Prostate Specific Antigen (Men, one per CY, age ≥ 50)                                                                                                                                             | No                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse                                                                                                  | No                                                      | Covered in Full                         | 40% 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                                                      | Covered in Full                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

| <b>MEDICAL SERVICES</b><br><i>All plan benefits shown as a percentage of Eligible Charge</i>                                                                                                                                                                                                                                                                                                          | <b>Do Services<br/>Require Prior<br/>Authorization?</b> | <b>Member Pays</b>                                                                                             |                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                         | <b>In-Network</b>                                                                                              | <b>Out-of-Network</b>                                                                         |
| <b>PREVENTIVE SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                                                                |                                                                                               |
| <b>Benefits For Women</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                |                                                                                               |
| 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                                                      | Covered in Full                                                                                                | 40% 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                                                      | Covered in Full                                                                                                | 40% 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                                                      | Covered in Full                                                                                                | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements                                                                                                                                                                                                                                                                                                         | No                                                      | Covered in Full                                                                                                | 40% 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.<br><br>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                                                      | Covered in Full                                                                                                | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| <b>HOSPITAL/FACILITY SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                                                                |                                                                                               |
| 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                                                     | \$450 Copayment plus amounts that exceed the Maximum Allowable Charge                                          |                                                                                               |
| Outpatient / Ambulatory Surgery Services & Birthing Centers                                                                                                                                                                                                                                                                                                                                           | Yes                                                     | \$150 Copayment plus amounts that exceed the Maximum Allowable Charge (waived if admitted to Inpatient status) |                                                                                               |
| Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)                                                                                                                                                                                                                                                                                                                             | Yes<br>(If at a hospital)                               | 20% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge                |                                                                                               |
| Emergency Room Services                                                                                                                                                                                                                                                                                                                                                                               | No                                                      | \$150 Copayment plus amounts that exceed the Maximum Allowable Charge (waived if admitted to Inpatient status) |                                                                                               |
| <b>DIAGNOSTIC SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                                                                |                                                                                               |
| <b>Laboratory Services</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                                                                |                                                                                               |
| Non-Hospital Based                                                                                                                                                                                                                                                                                                                                                                                    | No                                                      | Covered in Full                                                                                                | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based                                                                                                                                                                                                                                                                                                                                                                                        | Yes                                                     | 20% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge                |                                                                                               |

| <b>MEDICAL SERVICES</b><br><i>All plan benefits shown as a percentage of Eligible Charge</i> | <b>Do Services<br/>Require Prior<br/>Authorization?</b> | <b>Member Pays</b>                                                                              |                                                                                               |
|----------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
|                                                                                              |                                                         | <b>In-Network</b>                                                                               | <b>Out-of-Network</b>                                                                         |
| <b>DIAGNOSTIC SERVICES</b>                                                                   |                                                         |                                                                                                 |                                                                                               |
| <b>Radiology Services</b>                                                                    |                                                         |                                                                                                 |                                                                                               |
| Non-Hospital Based                                                                           | No                                                      | 20% Coinsurance after Annual Deductible                                                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based                                                                               | Yes                                                     | 20% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge |                                                                                               |
| <b>Radiation Oncology Services</b>                                                           |                                                         |                                                                                                 |                                                                                               |
| Non-Hospital Based                                                                           | Yes                                                     | 20% Coinsurance after Annual Deductible                                                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based                                                                               | Yes                                                     | 20% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge |                                                                                               |
| <b>CT/MRI/MRA/PET Scan</b>                                                                   |                                                         |                                                                                                 |                                                                                               |
| Non-Hospital Based                                                                           | Yes                                                     | 20% Coinsurance after Annual Deductible                                                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Hospital Based                                                                               | Yes                                                     | 20% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge |                                                                                               |
| <b>MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER</b>                              |                                                         |                                                                                                 |                                                                                               |
| <b>Inpatient</b>                                                                             |                                                         |                                                                                                 |                                                                                               |
| Hospital & Facility Services; semi-private room rate                                         | Yes                                                     | \$450 Copayment plus amounts that exceed the Maximum Allowable Charge                           |                                                                                               |
| Psychiatrist & Psychologist Services                                                         | No                                                      | 20% Coinsurance after Annual Deductible                                                         | 20% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| <b>Outpatient</b>                                                                            |                                                         |                                                                                                 |                                                                                               |
| Psychiatrist & Psychologist Services                                                         | Yes<br>(if at a hospital)                               | \$35 Copayment per visit                                                                        | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Psychological Testing                                                                        | Yes                                                     | 20% Coinsurance after Annual Deductible                                                         | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

| <b>MEDICAL SERVICES</b><br><i>All plan benefits shown as a percentage of Eligible Charge</i>                      | <b>Do Services<br/>Require Prior<br/>Authorization?</b>     | <b>Member Pays</b>                                                                                 |                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
|                                                                                                                   |                                                             | <b>In-Network</b>                                                                                  | <b>Out-of-Network</b>                                                                                     |
| <b>OTHER SERVICES</b>                                                                                             |                                                             |                                                                                                    |                                                                                                           |
| Allergy Testing<br>(Including serums, injections, and administration)                                             | No                                                          | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Ambulance (Ground & Air)                                                                                          | Yes<br>(Non-Emergent)                                       | \$200 Copayment plus amounts that exceed the<br>Maximum Allowable Charge                           |                                                                                                           |
| Chemotherapy                                                                                                      | Yes                                                         | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Dialysis and Supplies                                                                                             | Yes                                                         | 20% Coinsurance after Annual Deductible** Plus<br>amounts that exceed the Maximum Allowable Charge |                                                                                                           |
| Durable Medical Equipment<br>(Including Orthotics/Prosthetics)                                                    | Yes<br>(If greater than<br>\$500 charge per<br>single item) | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Enteral Nutrition Therapy                                                                                         | Yes                                                         | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Hearing Aids<br>(Limited to one (1) device per ear every five (5) years)<br>Maximum of \$1,500 per covered device | No                                                          | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Evaluations for the Use of Hearing Aids                                                                           | No                                                          | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Home Health Services<br>(Maximum of 120 visits per year)                                                          | Yes                                                         | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Home Infusion Services                                                                                            | Yes                                                         | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Hospice Services                                                                                                  | Yes                                                         | \$35 Copayment per visit                                                                           | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Human Growth Hormone, Genetic Testing/Counseling, Other                                                           | Yes                                                         | 20% Coinsurance after<br>Annual Deductible                                                         | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |
| Physical/Occupational/Speech Therapy (Non-Hospital Based)                                                         | Yes                                                         | \$35 Copayment per visit                                                                           | 40% Coinsurance after<br>Annual Deductible<br>plus amounts that<br>exceed the Maximum<br>Allowable Charge |

| <b>MEDICAL SERVICES</b><br><i>All plan benefits shown as a percentage of Eligible Charge</i>                                                    | <b>Do Services<br/>Require Prior<br/>Authorization?</b> | <b>Member Pays</b>       |                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------|
|                                                                                                                                                 |                                                         | <b>In-Network</b>        | <b>Out-of-Network</b>                                                                         |
| <b>ALTERNATIVE CARE SERVICES</b><br><b>There is a combined benefit year maximum of \$400.00 paid by the Plan for Alternative Care Services.</b> |                                                         |                          |                                                                                               |
| Acupuncture                                                                                                                                     | No                                                      | \$35 Copayment per visit | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Chiropractic Care                                                                                                                               | No                                                      | \$35 Copayment per visit | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Naturopathy                                                                                                                                     | No                                                      | \$35 Copayment per visit | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |
| Massage Therapy                                                                                                                                 | No                                                      | \$35 Copayment per visit | 40% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge |

\*\* In-Network Annual Deductible and Annual Out of Pocket Maximum applies. Amounts in excess of the Maximum Allowable Charge DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

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                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------|
| <b>PHARMACY PROVISIONS</b><br><i>Please refer to Member ID Card for Pharmacy Benefit Information</i>                                                                                                                                                                                                                                                                                                                                                                                    | Member Pays                                                                                     |                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | In-Network Pharmacies                                                                           | Out-of-Network Pharmacies |
| Annual Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | None                                                                                            | Not Applicable            |
| Annual Out of Pocket Maximum                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Combined with the Medical Out of Pocket Maximum                                                 | Not Applicable            |
| Lifetime Maximum                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | None                                                                                            | Not Applicable            |
| <b>PREVENTIVE PRESCRIPTION SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                           |
| <b>Mandatory Generic Only - Preventive Prescription Services as defined by PPACA.</b><br>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<br>Pharmacy Retail - up to a 30-Day Supply                                                                                                                                                                                                                                                                                                                                                                                                                           | Generic - \$0 Copayment                                                                         | Not Covered               |
| <b>NON-PREVENTIVE PRESCRIPTION SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                           |
| <b>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.</b> |                                                                                                 |                           |
| Prescription Drugs<br>Pharmacy Retail - up to a 30-Day supply                                                                                                                                                                                                                                                                                                                                                                                                                           | Generic - \$10 Copayment<br>Preferred Brand - \$20 Copayment<br>Non-Preferred - \$35 Copayment  | Not Covered               |
| Prescription Drugs<br>Pharmacy Retail – 90-Day Supply                                                                                                                                                                                                                                                                                                                                                                                                                                   | Generic - \$30 Copayment<br>Preferred Brand - \$60 Copayment<br>Non-Preferred - \$105 Copayment | Not Covered               |
| Prescription Drugs<br>Pharmacy Mail Order – 90-Day Supply                                                                                                                                                                                                                                                                                                                                                                                                                               | Generic - \$20 Copayment<br>Preferred Brand - \$40 Copayment<br>Non-Preferred - \$70 Copayment  | Not Covered               |
| Specialty Drugs                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 50% Coinsurance                                                                                 | 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.