

MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD BANNER 2024-2025

| VALUE GOLD BANNER 2024-2025 | TIER 1: BANNER HEALTH NETWORK | TIER 2: PARTICIPATING PROVIDERS | TIER 3: NON- PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|--|--|--|--|
| LIFETIME MAXIMUM BENEFIT | Unlimited | | |
| CALENDAR YEAR MAXIMUM BENEFIT | Unlimited | | |
| CALENDAR YEAR DEDUCTIBLE Single Family | \$600 \$1,200 | \$750 \$1,500 | \$3,000 \$9,000 |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card) Single Family | \$4,000 \$8,000 | \$5,000 \$10,000 | Not Applicable Not Applicable |
| MEDICAL BENEFITS | | | |
| Allergy Serum & Injections | | | |
| Injections (If no office visit charge) | 100% after \$5 Copay per visit; Deductible waived | 100% after \$5 Copay per visit; Deductible waived | 50% after Deductible |
| Serum | 100% after \$36 Copay per visit; Deductible waived | 100% after \$45 Copay per visit; Deductible waived | 50% after Deductible |
| Ambulance Services | | | |
| Ground Ambulance Services | 75% after Deductible | Paid at Tier 1 level of benefits | Paid at Tier 1 level of benefits |
| Air Ambulance Services | \$200 Copay per trip, then 75% after Deductible | Paid at Tier 1 level of benefits | Paid at Tier 1 level of benefits |
| Ambulatory Surgical Center | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Anesthesiologist | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Anti-Embolism Garments | \$40 Copay per pair, then 75%; Deductible waived | \$50 Copay per pair, then 75%; Deductible waived | \$50 Copay per pair, then 50% after Deductible |
| Calendar Year Maximum Benefit | 3 pairs | | |

| VALUE GOLD BANNER 2024-2025 | TIER 1: BANNER HEALTH NETWORK | TIER 2: PARTICIPATING PROVIDERS | TIER 3: NON- PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|--|--|--|
| Cardiac Rehab (Outpatient) | 100% after \$28 Copay per visit; Deductible waived | 100% after \$35 Copay per visit; Deductible waived | 50% after Deductible |
| Chemotherapy (Outpatient – includes all related charges) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Chiropractic Care/Spinal Manipulation | 100% after \$28 Copay per visit; Deductible waived | 100% after \$35 Copay per visit; Deductible waived | 50% after Deductible |
| Calendar Year Maximum Benefit | 20 visits | | |
| Diabetic Supplies | 100% after \$30 Copay per item; Deductible waived | 100% after \$30 Copay per item; Deductible waived | 50% after Deductible |
| Diagnostic Testing, X-Ray and Lab Services (Outpatient) | | | |
| Any Single Service Costing Less Than \$500 | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Any Single Service Costing \$500 or More | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Freestanding Laboratory | 75%; Deductible waived | 75%; Deductible waived | 50% after Deductible |
| Oncotype Diagnostic Testing | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Durable Medical Equipment (DME) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Emergency Services | | | |
| Emergency Medical Condition | | | |
| Facility Charges | 75% after Deductible | Paid at Tier 1 level of benefits | Paid at Tier 1 level of benefits |
| Professional Fees and Ancillary Charges | 75% after Deductible | Paid at Tier 1 level of benefits | Paid at Tier 1 level of benefits |
| Non-Emergency Medical Condition | | | |
| Facility Charges | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Professional Fees and Ancillary Charges | 75% after Deductible | 75% after Deductible | 50% after Deductible |

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|--|---|--|--|
| Empower Health (TIN: 36-4836722) | Not Applicable | 100%; Deductible waived | Not Applicable |
| NOTE: Empower Health wellness program is a voluntary wellness program available to the Employee only, Dependent Spouses and Children are not eligible. If you elect to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related choices. You will also be asked to complete a biometric screening, which will include a blood pressure reading and blood test. For more information regarding this program you may call Empower Health at (866) 367-6974. | | | |
| Foot Orthotics | \$40 Copay per orthotic, then 75%; Deductible waived | \$50 Copay per orthotic, then 75%; Deductible waived | \$50 Copay per orthotic, then 50% after Deductible |
| Maximum Benefit | Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months | | |
| Hearing Aids (including any office visit and any related services, includes cochlear Implants) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Maximum Benefit | 1 aid per ear per 36-month period | | |
| Hemodialysis (Outpatient) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Hinge Health Program (TIN 81-1884841) | Not Applicable | 100%; Deductible waived | Not Applicable |
| NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits. | | | |
| Home Health Care | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Calendar Year Maximum Benefit | 60 visits* | | |
| *Home health care supplies are not subject to the Calendar Year Maximum. | | | |
| Hospice Care | | | |
| Inpatient | \$200 Copay per admission, then 75%; Deductible waived | \$250 Copay per admission, then 75%; Deductible waived | \$300 Copay per admission, then 50% after Deductible |
| Outpatient | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges) | | | |
| Inpatient | \$200 Copay per admission, then 75%; Deductible waived | \$250 Copay per admission, then 75%; Deductible waived | \$300 Copay per admission, then 50% after Deductible |
| Room and Board Allowance | Semi-Private Room rate* | Semi-Private Room rate* | Semi-Private Room rate* |
| Outpatient | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| *Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary. | | | |

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|---|--|--|--|
| Infusion Therapy in Facility or Physician's Office | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Maternity (Non-Facility Charges)* | | | |
| Preventive Prenatal and Breastfeeding Support (other than lactation consultations) | 100%; Deductible waived | 100%; Deductible waived | 50% after Deductible |
| Breast Pumps | 100%; Deductible waived | 100%; Deductible waived | 100%; Deductible waived |
| Lactation Consultations | 100%; Deductible waived | 100%; Deductible waived | 100%; Deductible waived |
| All Other Prenatal, Delivery and Postnatal Care | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| * See Preventive Services under Eligible Medical Expenses for limitations. | | | |
| Medical and Surgical Supplies | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Mental Disorders and Substance Use Disorders | | | |
| Inpatient | | | |
| Facility Charge | \$200 Copay per admission, then 75%; Deductible waived | \$250 Copay per admission, then 75%; Deductible waived | \$300 Copay per admission, then 50% after Deductible |
| Professional Fees | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Outpatient Facility | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Office Visits | 100% after \$28 Copay; Deductible waived | 100% after \$35 Copay; Deductible waived | 50% after Deductible |
| NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized. | | | |
| Morbid Obesity (Surgical Treatment Only) | | | |
| Facility (Inpatient and outpatient) | \$200 Copay, then 75%; Deductible waived | \$250 Copay, then 75%; Deductible waived | 50% after Deductible |
| Professional Services | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Lifetime Maximum Benefit | 1 Surgical Procedure | | |
| Nutritional Food Supplements | 50% after Deductible | 50% after Deductible | 50% after Deductible |
| Occupational Therapy (Outpatient) | 100% after \$28 Copay per visit; Deductible waived | 100% after \$35 Copay per visit; Deductible waived | 50% after Deductible |
| Calendar Year Maximum Benefit | 60 visits | | |

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|--|--|--|--|
| Pain Management | Paid based on place of service | Paid based on place of service | Paid based on place of service |
| Calendar Year Maximum Benefit | Not Applicable | Not Applicable | 4 visits |
| Physical Therapy (Outpatient) | 100% after \$28 Copay per visit; Deductible waived | 100% after \$35 Copay per visit; Deductible waived | 50% after Deductible |
| Calendar Year Maximum Benefit | 60 visits | | |
| Physician's Services | | | |
| Inpatient/Outpatient Services | | | |
| Primary Care Physician Specialist | 75% after Deductible 75% after Deductible | 75% after Deductible 75% after Deductible | 50% after Deductible 50% after Deductible |
| Office Visits | | | |
| Primary Care Physician | 100% after \$28 Copay*; Deductible waived | 100% after \$35 Copay*; Deductible waived | 50% after Deductible |
| Specialist | 100% after \$36 Copay*; Deductible waived | 100% after \$45 Copay*; Deductible waived | 50% after Deductible |
| Physician Office Surgery | | | |
| Primary Care Physician | Under \$1,000 - 100% after \$28 Copay*; Deductible waived; \$1,000 or more – 75% after Deductible | Under \$1,000 - 100% after \$35 Copay*; Deductible waived; \$1,000 or more – 75% after Deductible | 50% after Deductible |
| Specialist | Under \$1,000 - 100% after \$36 Copay*; Deductible waived; \$1,000 or more – 75% after Deductible | Under \$1,000 - 100% after \$45 Copay*; Deductible waived; \$1,000 or more – 75% after Deductible | 50% after Deductible |
| *Copay applies per visit regardless of what services are rendered. | | | |

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|--|--|--|--|
| Preventive Services and Routine Care | | | |
| Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service) | 100%; Deductible waived | 100%; Deductible waived | Not Covered |
| Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above) | 100% of the first \$300 per Calendar Year, then 10%; Deductible waived | 100% of the first \$300 per Calendar Year, then 10%; Deductible waived | Not Covered |
| Flu, Pneumonia & Shingles Vaccinations | 100%; Deductible waived | 100%; Deductible waived | 100%; Deductible waived |
| Routine Hearing Exam | 100% after \$28 Copay per exam; Deductible waived | 100% after \$35 Copay per exam; Deductible waived | 50% after Deductible |
| Calendar Year Maximum Benefit | 1 exam | | |
| NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details. | | | |
| Prosthetics (other than bras) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Prosthetic Bras | 75% after Deductible | 75% after Deductible | 75% after Deductible |
| Calendar Year Maximum Benefit | 2 bras | | |
| Psychological and Neuropsychological Testing | 50% after Deductible | 50% after Deductible | 50% after Deductible |
| Radiation Therapy (Outpatient - includes all related charges) | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders) | \$200 Copay per admission, then 75%; Deductible waived | \$250 Copay per admission, then 75%; Deductible waived | \$300 Copay per admission, then 50% after Deductible |
| Calendar Year Maximum Benefit | 60 days | | |
| Skilled Nursing Facility | \$200 Copay per admission, then 75%; Deductible waived | \$250 Copay per admission, then 75%; Deductible waived | \$300 Copay per admission, then 50% after Deductible |
| Maximum Benefit per 12 Month Period | 60 days | | |
| SkinIO Provider (Skin Cancer Screenings) | Not Applicable | 100%; Deductible waived | Not Applicable |
| NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 82-2035738 | | | |

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|---|---|---|---|
| Speech Therapy (Outpatient) | 100% after \$28 Copay per visit; Deductible waived | 100% after \$35 Copay per visit; Deductible waived | 50% after Deductible |
| Calendar Year Maximum Benefit | 60 visits | | |
| Surgery (Inpatient) | | | |
| Facility | \$200 Copay per admission, then 75%; Deductible waived | \$250 Copay per admission, then 75%; Deductible waived | 50% after Deductible |
| Professional Services | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Surgery (Outpatient) (does not include Surgery in the Physician's office) | | | |
| Facility | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Professional Services | 75% after Deductible | 75% after Deductible | 50% after Deductible |
| Teladoc Network Providers | Not Applicable | 100%; Deductible waived | Not Applicable |
| Telemedicine | | | |
| Mental Disorders & Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders |
| All Other Provider Services | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) |
| Temporomandibular Joint Dysfunction (TMJ) | \$40 Copay per occurrence, then 75%; Deductible waived | \$50 Copay per occurrence, then 75%; Deductible waived | \$50 Copay per occurrence, then 50% after Deductible |
| Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services | 1 Surgical Procedure 1 appliance \$1,000 | | |

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|---|---|---|--|
| Transplants | | | |
| Facility Charges | \$200 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)* | \$250 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)* | Not Covered |
| Professional Fees | 75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers) | 75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers) | Not Covered |
| * Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible. | | | |
| NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness. | | | |
| Urgent Care Facility | \$46 Copay* per visit, then 100%; Deductible waived | \$55 Copay* per visit, then 100%; Deductible waived | 50% after Deductible |
| *Copay applies per visit regardless of what services are rendered. | | | |
| Virta Health Providers (TIN 36-4841662) | 100%; Deductibles and Copays waived | Paid at Tier 1 level of benefits | Not Applicable |
| NOTE: Virta Health is an online specialty medical clinic that reverses Type 2 diabetes safely and sustainably, without the risks, costs, or side effects of medications or Surgery. For more information you may complete an application at www.virtahealth.com . | | | |
| Wig (see Eligible Medical Expenses) | \$40 Copay per wig, then 75%; Deductible waived | \$50 Copay per wig, then 75%; Deductible waived | \$50 Copay per wig, then 75%; Deductible waived |
| Maximum Benefit per 24 Month Period | 1 wig | | |
| All Other Eligible Medical Expenses | \$40 Copay*, then 75%; Deductible waived | \$50 Copay*, then 75%; Deductible waived | \$50 Copay*, then 50% after Deductible |
| *Copay applies per eligible item, service or occurrence. | | | |

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – VALUE GOLD BANNER 2024-2025

| BENEFIT DESCRIPTION | BENEFIT |
|--|---|
| NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy. | |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket) | |
| Single | \$5,000 |
| Family | \$10,000 |
| Retail Pharmacy: 30-day supply | |
| Generic Drug | \$15 Copay |
| Preferred Drug | 20% Copay (\$25 minimum, \$80 maximum) |
| Non-Preferred Drug | 40% Copay (\$40 minimum, \$110 maximum) |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | \$0 Copay (100% paid) |
| Diabetic Insulin Medications | |
| Generic | \$5 Copay |
| Brand | \$15 Copay |
| Diabetic Supplies | |
| Generic | \$5 Copay |
| Brand | \$15 Copay |
| Specialty Pharmacy Network: 30-day supply | |
| Specialty Drug | |
| Specialty Drugs Not Available Through PrudentRx Solution | \$200 Copay |
| Enrolled and Available with PrudentRx Solution | \$0 Copay |
| Not Enrolled and Available with PrudentRx Solution | 30% Copay |
| NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details. | |
| NOTE: PrudentRx Solution assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a \$0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution program. | |
| CVS Maintenance Choice – Allow Opt-Out: 90-day supply | |
| Generic Drug | \$30 Copay |
| Preferred Drug | 20% Copay (\$50 minimum, \$175 maximum) |
| Non-Preferred Drug | 40% Copay (\$80 minimum, \$225 maximum) |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | \$0 Copay (100% paid) |

| | |
|---|---|
| Diabetic Insulin Medications | |
| Generic | \$10 Copay |
| Brand | \$30 Copay |
| Diabetic Supplies | |
| Generic | \$10 Copay |
| Brand | \$30 Copay |
| Mail Order: 90-day supply | |
| Generic Drug | \$30 Copay |
| Preferred Drug | 20% Copay (\$50 minimum, \$175 maximum) |
| Non-Preferred Drug | 40% Copay (\$80 minimum, \$225 maximum) |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | \$0 Copay (100% paid) |
| Diabetic Insulin Medications | |
| Generic | \$10 Copay |
| Brand | \$30 Copay |
| Diabetic Supplies | |
| Generic | \$10 Copay |
| Brand | \$30 Copay |

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Generic Program

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out

The Plan allows for 2 30-day fills of maintenance drugs at any Participating retail pharmacy. After 2 fills, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Pharmacy Network

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician’s office, infusion center or other clinical setting, or the Covered Person’s home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Advanced Control Specialty Formulary

Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

PrudentRx Copay Program for Specialty Medications

In order to provide a comprehensive and cost-effective Prescription Drug program for you and your family, your Employer has contracted to offer the PrudentRx Solution for certain Specialty Drugs. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% Copay. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their Specialty Drugs, the member will have a \$0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing Out-of-Pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more Specialty Drugs included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at (800) 578-4403 to register for any manufacturer copay assistance program available for your Specialty Drug as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call (800) 578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your Plan Deductible or Out-of-Pocket Maximum (if applicable), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your Deductible or Out-of-Pocket Maximum (if any), unless otherwise required by law. A list of Specialty Drugs that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.