EASE | Health Plans

100% compliant with the Patient Protection and Affordable Care Act

Ease Health Plans fulfill the two basic requirements of the Patient Protection and Affordable Care Act.

A — Minimum Essential Coverage

MEC required coverage

All companies with 50 or more full-time and/or full-time equivalent employees must provide coverage for certain types of wellness and preventative care. This is called "Minimum Essential Coverage," or "MEC".

We provide all of these important benefits at an average cost of about $100 per employee per month!

B — Minimum Value Plan

MVP options

The second ACA requirement is that employers must offer – but are not required to pay the entire cost of – an affordable "Minimum Value Plan," or "MVP". MVPs are plans that offer substantial coverage for inpatient hospitalization and physician services under which the plan's share of the total allowed costs of benefits is at least 60%.

Our Ease Bronze and Ease Silver plans meet the criteria of an ACA-compliant Minimum Value plan.

Companies using both plans archive: 100% ACA COMPLIANCE

What happens if a company fails to provide an with more than 50 employees ACA-compliant plan?

A TAX

Large Employers who fail to offer MEC to at least 95% of full-time employees and dependents may be subject to a penalty of $2,570 per full-time employee minus the first 30.

B TAX

The "B Tax" is a $3,860 annual penalty per full-time employee enrolled in a subsidized plan through a government exchange whenever a Large Employer fails to offer an affordable MVP.

MEDICAL PLAN COMPARISON

	EASE | Primary	WELLPREMIUM	EASE | Bronze	EASE | Silver
Deductible | Individual	$0	$0	$0	$0
Deductible | Family	$0	$0	$0	$0
Out of Pocket Maximum | Individual	N/A	$8,550	$8,550	$5,000
Out of Pocket Maximum | Family	N/A	$17,100	$17,100	$10,000
Preventive & Wellness Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Telehealth – Unlimited Visits	$0 Consult Fee	$0 Consult Fee	$0 Consult Fee	$0 Consult Fee
Preventive Prescription | Generic Drugs	$0 copay (Limited to preventive only)	$0 Copay (Limited to preventive only)	$0 copay (Limited to preventive only)	$0 copay (Limited to preventive only)
Prescription Benefits	Tier 1 = $0 (Over 200 drugs) Tier 2 = $10 (Or less) Tier 3 = $25 (Over 600 drugs) Tier 4 = $50 (Or less)	Tier 1 = $0 (Over 200 drugs) Tier 2 = $10 (Or less) Tier 3 = $25 (Over 600 drugs) Tier 4 = $50 (Or less)	Preferred Generic = $0 Copay Formulary Generic = $10 Copay Formulary Brand Name = $30 Copay Additional Preferred Brand & Generic = $50 or Less	Preferred Generic = $0 Copay Formulary Generic = $10 Copay Formulary Brand Name = $30 Copay Additional Preferred Brand & Generic = $50 or Less
Primary Care Office Visit	Not Covered	Existing Doctor: $35 Copay New Doctor: $70 Copay	$25 Copay (Limit of 8 visits per plan year)	$15 Copay (Limit of 10 visits per plan year)
Urgent Care Visit		$75 Copay	$50 Copay (Limit of 2 visits per plan year)	$35 Copay (Limit of 3 visits per plan year)
Specialist Office Visit		Existing Doctor: $75 Copay New Doctor: $150 Copay	$50 Copay (Limit of 8 visits per plan year)	$25 copay (Limit of 10 visits per plan year)
Laboratory Service and Radiology		$50 Copay	$50 Copay (Limited to 3 per plan year)	$50 Copay (Limited to 3 per plan year)
CT/MRI/MRA/PET Scans		$500 Copay (Limited 1)	$350 Copay (Limited to 1 per plan year)	$350 Copay (Limited to 2 per plan year)
Inpatient Hospitalization & Inpatient Surgery		Not Covered	$350 Copay Per Admission (Limited to 5 days and 2 surgeries)	$350 Copay Per Admission (Limited to 7 days and 3 surgeries)
Outpatient Hospital or Free-Standing Facility Services and Surgery			$350 Copay (Limited to 1 visit per plan year)	$350 Copay (Limited to 2 visits per plan year)
Emergency Room			$350 Copay (Limited to 1 visit per plan year)	$350 Copay (Limited to 1 visit per plan year)
Treatment for Chemical Abuse & Dependency			Outpatient: $25 Copay Per Day Inpatient: $250 Copay Per Day (Both limited to 5 days per plan year)	Outpatient: $25 Copay Per Day Inpatient: $250 Copay Per Day (Both limited to 7 days per plan year)
Home Health Care			$25 Copay (Limited to 10 visits per plan year)	$25 Copay (Limited to 10 visits per plan year)
Pregnancy Benefits			Not Covered	$350 Copay (Professional Services) $350 Copay Per Admission (Childbirth/Delivery)

PLEASE NOTE: Please refer to the Schedule of Benefits for the official list of Benefits Coverage, Limitations, and Exclusions. If plan comparison differs from the Schedule of Benefits, the Schedule of Benefits will govern.

EASE | Health Plans

MEDICAL PLAN RATES

Valued Client				
	Ease Primary™	Well Premium™	Ease Bronze™	Ease Silver™
Member Only Rate	**$139.34**	**$206.66**	**$550.66**	**$684.00**
Member + Spouse Rate	**$160.00**	**$311.33**	**$781.34**	**$908.00**
Member + Child(ren) Rate	**$152.00**	**$317.34**	**$723.33**	**$836.00**
Member + Family Rate	**$184.01**	**$415.33**	**$1,052.00**	**$1,232.01**

PROPOSAL NOTES:

- Rates include ACH fee.
- Please refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations, and Exclusions before enrolling.
- Claims Cost is based on separate actuarial data from general demographics of participants of corresponding plan designs and their projected claims. Claims Cost is unrelated to any specific contract for insurance.
- Rates do not include Credit Card fee of 4%.
- Excepted benefits are subject to different terms and conditions and are separate, uncoordinated plans. This plan is not dependent on or interactive with plans not subject to the Patient Protection and Affordable Care Act.
- Plans provide coverage for the preventive health and wellness services required by the Affordable Care Act's PHSA & Sec. 2713 (a).
- This program is a self-insured program. Suffolk Administrative Services, LLC., any of its members, or any of its affiliates are not liable for payment of any claims related to this program and do not sell, negotiate, or market insurance products.
- All plan rates are subject to change.
- The delivery of products and/or services from any vendor associated with the plans presented in this proposal will only be provided after receipt and acknowledgment, by the parties, of a fully executed service contract and is subject to the terms and conditions thereof. This is not a contract.

EASE | Health Plans

DENTAL PLAN COMPARISON

Benefits Summary	Ease Dental 1.5	Ease Dental 3.0
Individual Deductible	$0	
Family Deductible	$0	
Individual Maximum Benefit	$1,500	$3,000
Family Maximum Benefit	$3,000	$6,000
Preventive/ Diagnostic Services		
Oral Examinations	0% Coinsurance	
Cleanings Adult/Child	0% Coinsurance	
Fluoride	0% Coinsurance	
Sealants (permanent molars only)	0% Coinsurance	
Bitewing X-rays	0% Coinsurance	
Basic Restorative Services		
Full mouth series X-ray	20% Coinsurance	
Restorative Amalgam or Composite	20% Coinsurance	
Routine Tooth Extraction	20% Coinsurance	
Major Restorative Services		
Endodontics	50% Coinsurance	
Periodontics	50% Coinsurance	
Dentures	50% Coinsurance	
Crowns	50% Coinsurance	
Complex Extractions	50% Coinsurance	
Local Anesthesia	50% Coinsurance	
Onlays	50% Coinsurance	
Implants	50% Coinsurance	

PLEASE NOTE: Please refer to the Schedule of Benefits for the official list of Benefits Coverage, Limitations, and Exclusions. If plan comparison differs from the Schedule of Benefits, the Schedule of Benefits will govern.

EASE | Health Plans

DENTAL PLAN RATES

Valued Client				
	Ease Dental 1.5™		Ease Dental 3.0™	
	Ages 18 - 39	Ages 40 - 64	Ages 18 - 39	Ages 40 - 64
Member Only Rate	**$70.10**	**$81.75**	**$76.43**	**$89.84**
Member + Spouse Rate	**$111.13**	**$134.39**	**$123.72**	**$150.56**
Member + Child(ren) Rate	**$116.89**	**$141.82**	**$130.39**	**$159.10**
Member + Family Rate	**$169.85**	**$209.76**	**$191.45**	**$237.53**

PROPOSAL NOTES:

- Rates do inculde ACH Fee.
- Please refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations, and Exclusions before enrolling.
- Claims Cost is based on separate actuarial data from general demographics of participants of corresponding plan designs and their projected claims. Claims Cost is unrelated to any specific contract for insurance.
- Rates do not include Credit Card fee of 4%.
- Excepted benefits are subject to different terms and conditions and are separate, uncoordinated plans. This plan is not dependent on or interactive with plans not subject to the Patient Protection and Affordable Care Act.
- Plans provide coverage for the preventive health and wellness services required by the Affordable Care Act's PHSA & Sec. 2713 (a).
- This program is a self-insured program. Suffolk Administrative Services, LLC., any of its members, or any of its affiliates are not liable for payment of any claims related to this program and do not sell, negotiate, or market insurance products.
- All plan rates are subject to change.
- The delivery of products and/or services from any vendor associated with the plans presented in this proposal will only be provided after receipt and acknowledgment, by the parties, of a fully executed service contract and is subject to the terms and conditions thereof. This is not a contract.

EASE | Health Plans

EASE | Primary

DEDUCTIBLE (Individual | Family)	$0 | $0
OUT OF POCKET MAXIMUM (Individual | Family)	$0 | $0
PREVENTIVE & WELLNESS SERVICES	$0 Copay (Plan pays 100% of covered preventive and wellness services)
TELEMEDICINE SERVICES	$0
PHARMACY BENEFITS (Subject to Formulary)	Generic - $0 Copay (Limited to Preventive Generic drugs. Plan pays 100% of covered preventive drugs. In addition, a discount pharmacy program is provided that allows other drugs to be obtained at payments ranging from $0 to $50).

PLEASE NOTE:

- Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.
- Refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.

WELLPREMIUM™

The WellPREMIUM™ Plan provides coverage for the preventive health services required by the PHSA § 2713 (a) without any cost sharing requirements. All covered In Network preventive service will be 100% covered by the Plan. Out of Network services will not be covered unless otherwise specified, and the Plan Member will owe 100% of the cost of these services.

Deductible and Out of Pocket		
In Network Services	**Deductible**	**Out of Pocket Maximum**
Individual	$0	$8,550
Family	$0	$17,100

Overview of Benefits			
Medical Service	**Participating Providers** (In Network)	**Non-Participating Providers** (Out of Network)	**Limitations & Exclusions**
	Member Pays		
Preventive & Wellness Services	$0 Copay (Plan pays 100% of covered preventive and wellness services)	Not Covered -100% paid by Member	Some services are subject to age and other limitations. Not covered if services are provided at a hospital.
Primary Care Office Visit	$35 Copay Existing Doctor $70 Copay New Doctor	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Specialist Office Visit	$75 Copay Existing Doctor $150 Copay New Doctor	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Laboratory Service	$50 Copay per panel tested	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Radiology	$50 Copay per image billed	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
CT/MRI/MRA/PET Scan	$500 Copay per image billed	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Urgent Care	$75 Copay	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Inpatient Room & Board	Not Covered -100% paid by Member	Not Covered -100% paid by Member	(Including Mental & Behavioral Health or Substance Abuse)
Other Inpatient Services	Not Covered -100% paid by Member	Not Covered -100% paid by Member	Not covered
Emergency Room Services	Not Covered -100% paid by Member	Not Covered -100% paid by Member	Not covered
Rehabilitation/Habilitation Services	Not Covered -100% paid by Member	Not Covered -100% paid by Member	Not covered
Pharmacy Benefits - (Subject to Formulary)			
Preventive Prescription Services	Generic - $0 Copay (Limited to Preventive Generic)	Not Covered -100% paid by Member	Limited to recommended preventive care as outlined by the Patient Protection & Affordable Care Act
ARRIVERX Pharmacy Program	Tier 1 = $0 Participant Payment (Over 200 Drugs) Tier 2 = $10 Participant Payment (Or less) Tier 3 = $25 Participant Payment (Over 600 Drugs) Tier 4 = $50 Participant Payment (Or less)		Drugs can be obtained at payments ranging from $0 to $50

NOTE:

- **Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.**
- **Refer to the Schedule of Benefits or ARRIVERX Product Flyer, as applicable, for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits or ARRIVERX Product Flyer, the Schedule of Benefits or ARRIVERX Product Flyer, as applicable, will govern.**

EASE | Health Plans

EASE | Bronze

DEDUCTIBLE (Individual | Family)	$0 | $0
OUT OF POCKET MAXIMUM (Individual | Family)	$8,550 | $17,100
PREVENTIVE & WELLNESS SERVICES	$0 Copay (Plan pays 100% of covered preventive and wellness services)
TELEMEDICINE SERVICES	$0
PRIMARY CARE OFFICE VISIT	$25 Copay (Limited to 8 visits per plan year)
SPECIALIST OFFICE VISIT	$50 Copay (Limited to 8 visits per plan year)
LABORATORY SERVICE & RADIOLOGY	$50 Copay (Combined limit of 3 visits per plan year)
CT/MRI/MRA/PET SCAN	$350 Copay (Limited to 1 per plan year)
URGENT CARE	$50 Copay (Limited to 2 visits per plan year)
OUTPATIENT HOSPITAL OR FREE STANDING FACILITY SERVICES AND SURGERY	$350 Copay (Limited to 1 visit per plan year)
INPATIENT HOSPITALIZATION & INPATIENT SURGERY	$350 Copay per admission (Limited to 5 days and 2 Surgeries per plan year)
EMERGENCY ROOM SERVICES	$350 Copay (Limited to 1 visit per plan year)
PHARMACY BENEFITS (Subject to Formulary)	Generic (Limited to preventive only) - $0 Copay Preferred Generic = $0 Copay Formulary Generic = $10 Copay Formulary Brand Name = $30 Copay Additional Preferred Brand & Generic = $50 or Less
TREATMENT FOR CHEMICAL ABUSE & DEPENDENCY	Outpatient: $25 Copay per day Inpatient: $250 Copay per day (Both limited to 5 days per plan year)
HOME HEALTH CARE	$25 Copay (Limited to 10 visits per plan year)

PLEASE NOTE:

- Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.
- Refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.

EASE | Health Plans

EASE | Silver

DEDUCTIBLE (Individual | Family)	$0 | $0
OUT OF POCKET MAXIMUM (Individual | Family)	$5,000 | $10,000
PREVENTIVE & WELLNESS SERVICES	$0 Copay (Plan pays 100% of covered preventive and wellness services)
TELEMEDICINE SERVICES	$0
PRIMARY CARE OFFICE VISIT	$15 Copay (Limited to 10 visits per plan year)
SPECIALIST OFFICE VISIT	$25 Copay (Limited to 10 visits per plan year)
LABORATORY SERVICE & RADIOLOGY	$50 Copay (Combined limit of 3 visits per plan year)
CT/MRI/MRA/PET SCAN	$350 Copay (Limited to 2 per plan year)
URGENT CARE	$35 Copay (Limited to 3 visits per plan year)
OUTPATIENT HOSPITAL OR FREE STANDING FACILITY SERVICES AND SURGERY	$350 Copay (Limited to 2 visits per plan year)
INPATIENT HOSPITALIZATION & INPATIENT SURGERY	$350 Copay per admission (Limited to 7 days and 3 Surgeries per plan year)
EMERGENCY ROOM SERVICES	$350 Copay (Limited to 1 visit per plan year)
PREGNANCY BENEFITS	Professional Services: $350 Copay Childbirth/Delivery: $350 Copay per admission
PHARMACY BENEFITS (Subject to Formulary)	Generic (Limited to preventive only) - $0 Copay Preferred Generic = $0 Copay Formulary Generic = $10 Copay Formulary Brand Name = $30 Copay Additional Preferred Brand & Generic = $50 or Less
TREATMENT FOR CHEMICAL ABUSE & DEPENDENCY	Outpatient: $25 Copay per day Inpatient: $250 Copay per day (Both limited to 7 days per plan year)
HOME HEALTH CARE	$25 Copay (Limited to 10 visits per plan year)

PLEASE NOTE:

- Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.
- Refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.

EASE | Dental 1.5™

Individual Annual Deductible	$0
Family Annual Deductible	$0
Individual Maximum Benefit	$1,500
Family Maximum Benefit	$3,000
Network	Dentemax

List of Services

PREVENTIVE/DIAGNOSTIC SERVICES	MEMBER PAYS	LIMITATIONS
Oral examinations	0% Coinsurance	1 per consecutive 6 month period
Cleanings Adult/Child	0% Coinsurance	1 per consecutive 6 month period
Fluoride	0% Coinsurance	1 per consecutive 6 month period
Sealants (permanent molars only)	0% Coinsurance	1 treatment per tooth per consecutive 36 month period
Bitewing X-rays	0% Coinsurance	1 set per consecutive 12 month period

BASIC RESTORATIVE SERVICES	MEMBER PAYS	LIMITATIONS
Full mouth series X-rays*	20% Coinsurance	A waiting period of 6 months applies in connection with all Basic Restorative Services. *1 per consecutive 60 month period
Restorative Amalgam or Composite	20% Coinsurance	
Routine Tooth Extraction	20% Coinsurance	

MAJOR RESTORATIVE SERVICES	MEMBER PAYS	LIMITATIONS
Endodontics	50% Coinsurance	A waiting period of 12 months applies in connection with all Major Restorative Services.
Periodontics	50% Coinsurance	
Dentures	50% Coinsurance	
Crowns	50% Coinsurance	
Complex Extraction	50% Coinsurance	
Local Anesthesia	50% Coinsurance	
Onlays	50% Coinsurance	
Implants	50% Coinsurance	

EASE | Dental 1.5™

Exclusions & Limitations

1. Procedures which are not necessary and which do not have uniform professional endorsement.
2. Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
3. Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
4. Replacement of lost or stolen appliances or dentures.
5. Replacement of teeth beyond the normal complement of 32.
6. Prescription drugs.
7. Orthodontic treatment.
8. Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
9. Charges for travel time, transportation costs or professional advice given on the phone.
10. Any charge for any treatment performed outside of the United States other than for emergency treatment.
11. Oral hygiene, plaque control, tobacco, and diet instruction, broken appointments, completion of claim forms, personal supplies (water pick, toothbrush, floss holder, etc.), duplication of x-rays and exams required by a third party.
12. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
13. Services that are deemed to be medical services.
14. Services or appliances which restore or alter occlusion or vertical dimension.
15. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
16. Fixed and removable appliances for correction of harmful habits.
17. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
18. Any item or procedure not specifically covered under this Schedule of Benefits.
19. This plan does not cover any services performed by out of network providers.

•The waiting period is the amount of time you must be enrolled in the plan before you are eligible to receive plan benefits for the treatments subject to the waiting period. For example, you enrolled in coverage effective July 1, the plan will not cover any portion of the costs for a basic restorative service until January 1 of the next year. The plan will not cover any portion of the costs for a major restorative service until July 1 of the next year.

•The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

EASE | Dental 3.0™

Individual Annual Deductible	$0
Family Annual Deductible	$0
Individual Maximum Benefit	$3,000
Family Maximum Benefit	$6,000
Network	Dentemax

List of Services

PREVENTIVE/DIAGNOSTIC SERVICES	MEMBER PAYS	LIMITATIONS
Oral examinations	0% Coinsurance	1 per consecutive 6 month period
Cleanings Adult/Child	0% Coinsurance	1 per consecutive 6 month period
Fluoride	0% Coinsurance	1 per consecutive 6 month period
Sealants (permanent molars only)	0% Coinsurance	1 treatment per tooth per consecutive 36 month period
Bitewing X-rays	0% Coinsurance	1 set per consecutive 12 month period

BASIC RESTORATIVE SERVICES	MEMBER PAYS	LIMITATIONS
Full mouth series X-rays*	20% Coinsurance	A waiting period of 6 months applies in connection with all Basic Restorative Services. *1 per consecutive 60 month period
Restorative Amalgam or Composite	20% Coinsurance	
Routine Tooth Extraction	20% Coinsurance	

MAJOR RESTORATIVE SERVICES	MEMBER PAYS	LIMITATIONS
Endodontics	50% Coinsurance	A waiting period of 12 months applies in connection with all Major Restorative Services.
Periodontics	50% Coinsurance	
Dentures	50% Coinsurance	
Crowns	50% Coinsurance	
Complex Extraction	50% Coinsurance	
Local Anesthesia	50% Coinsurance	
Onlays	50% Coinsurance	
Implants	50% Coinsurance	

Exclusions & Limitations

1. Procedures which are not necessary and which do not have uniform professional endorsement.
2. Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
3. Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
4. Replacement of lost or stolen appliances or dentures.
5. Replacement of teeth beyond the normal complement of 32.
6. Prescription drugs.
7. Orthodontic treatment.
8. Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
9. Charges for travel time, transportation costs or professional advice given on the phone.
10. Any charge for any treatment performed outside of the United States other than for emergency treatment.
11. Oral hygiene, plaque control, tobacco, and diet instruction, broken appointments, completion of claim forms, personal supplies (water pick, toothbrush, floss holder, etc.), duplication of x-rays and exams required by a third party.
12. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
13. Services that are deemed to be medical services.
14. Services or appliances which restore or alter occlusion or vertical dimension.
15. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
16. Fixed and removable appliances for correction of harmful habits.
17. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
18. Any item or procedure not specifically covered under this Schedule of Benefits.
19. This plan does not cover any services performed by out of network providers.

•The waiting period is the amount of time you must be enrolled in the plan before you are eligible to receive plan benefits for the treatments subject to the waiting period. For example, you enrolled in coverage effective July 1, the plan will not cover any portion of the costs for a basic restorative service until January 1 of the next year. The plan will not cover any portion of the costs for a major restorative service until July 1 of the next year.

•The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

ArriveRx

Prescription Drug Plan Services

NBFSA, LLC, a licensed Third Party Administrator and Pharmacy Benefit Manager, provides prescription drug plan administrative services to assist groups provide their members with enhanced prescription drug program solutions. NBFSA has developed the ArriveRx.com Platform through which it delivers turn key prescription drug benefit plan administrative support services on behalf of client groups for their members. A popular benefit plan design selected by other clients provides the following:

1. Preferred Drug Formulary:

- Preferred drug formulary organizing drugs into five (5) pricing tiers:
  - Preventive medications provided at no cost*
  - $0.00 (over 200 drugs at no cost)
  - $10.00 (or less)
  - $25.00 (Over 600 drugs under $25)
  - $50.00 (or less)
- Non-formulary Drugs at a Discount

*U.S. Preventive Services Task Force A & B Recommendation Medications and Supplements; The health reform law (Affordable Care Act) makes certain preventive medications and supplements available to you at no cost—both prescription and over-the-counter (OTC). The preventive medications in the attached list are covered at 100% with $0 copay when: Prescribed by a health care professional; Age and/or condition appropriate; Filled at a network pharmacy.

2. Preferred Pharmacy Network:

- Professionals are available toll-free to assist members identify the most affordable alternatives

3. Telephone Access to Live Prescription Drug Pricing Assistance

- Access to preferred network of over 60,000 pharmacies

4. Online Member Resources:

- Compare pricing across local pharmacies
- Identify more affordable (generic and brand) prescription alternatives
- Access to drug information & view drug images
- Text member card and vouchers to you phone

5. Family Benefit

- Program benefits are available to all family members

ArriveRx is a platform which supports group sponsored prescription drug benefit plans. Access to the benefit plans hosted on the ArriveRx platform and any use of the ArriveRx platform is restricted to designated groups and their eligible members. ArriveRx is not intended for use related to programs that are made available to the general public.
*The attached list represents some of the most commonly prescribed drugs . It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

Prescription Drug Benefits:

Generic Preventive Medications	
Generic Preventive Medications:	$0 Copay

Preferred Formulary Prescription Drugs	
Preferred Generics:	$0 Copay
Formulary Generic Drugs:	$10 Copay
Formulary Brand Name Drugs:	$30 Copay
Additional preferred Brand & Generic Drugs:	$50 or less

Copays listed apply only to drugs listed on the formulary
Subject to an annual deductible of $1,000 per person / $2,000 per family
Maximum monthly benefit of $1,000 per person / $2,000 per family

Non-Formulary Prescription Drugs are provided at our negotiated network rates savings members up to 90% off the usual and customary charge

Features and Benefits:

- Preferred pharmacy network accepted at over 60,000 participating pharmacies
- Live prescription drug pricing assistance, toll-free to assist members identify the most affordable alternatives
- On-line and mobile device pricing tools
- Access to patient assistance programs for high dollar non-formulary drugs

All members are enrolled into Alliance for Consumers USA to be eligible to receive the prescription drug insurance benefits. The prescription drug insurance benefits are underwritten by Greenwich Insurance Company under policy issued to Alliance for Consumers USA. The Elite Data LP Plan fees charged for their plan will include the insurance premiums listed that will be paid to Greenwich Insurance Company for the prescription drug benefits. These premium rates do not include PBM administrative fees which are being billed under the ArriveRx program. Greenwich Insurance Company provides only the prescription drug benefit insurance. Greenwich does not provide nor is affiliated with the other benefits or services provided as a part of membership. Refer to the Prescription Drug Description of Benefits for more details.