

| SimplyBlue Plus Platinum 2   |                                                                                                                                                                                                                                                             |                                                       |
|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Plan Overview                |                                                                                                                                                                                                                                                             |                                                       |
| Plan ID                      | 78124NY0980026-00                                                                                                                                                                                                                                           |                                                       |
| Plan Name                    | SimplyBlue Plus Platinum 2                                                                                                                                                                                                                                  |                                                       |
| Aggregation Design           | Individual Aggregation                                                                                                                                                                                                                                      |                                                       |
| Plan Highlights              | Predictable out-of-pocket costs without a deductible, includes ThriveWell <sup>SM</sup> .                                                                                                                                                                   |                                                       |
| Plan Type                    | Copay                                                                                                                                                                                                                                                       |                                                       |
| HSA Eligible                 | No                                                                                                                                                                                                                                                          |                                                       |
| Quote Effective              | 01/01/2027 - 03/31/2027                                                                                                                                                                                                                                     |                                                       |
| Plan Feature                 |                                                                                                                                                                                                                                                             |                                                       |
| Primary Care Physician (PCP) | Not Required                                                                                                                                                                                                                                                |                                                       |
| Referrals                    | Not Required                                                                                                                                                                                                                                                |                                                       |
| Out of Network Benefits      | Covered at 80%, subject to the deductible                                                                                                                                                                                                                   |                                                       |
| Out of Area Benefits         | Coverage provided worldwide through our BlueCard® Network                                                                                                                                                                                                   |                                                       |
| Student/Dependent Coverage   | Qualified dependents are covered to age 26                                                                                                                                                                                                                  |                                                       |
| Domestic Partner             | Covered                                                                                                                                                                                                                                                     |                                                       |
| Wellness Incentives          | ThriveWell <sup>SM</sup> , a digital home base dedicated to engaging in health and wellbeing. This digital hub includes rewards of up to \$200 per subscriber and \$200 per spouse, or domestic partner, for a total rewards payout of \$400 per plan year. |                                                       |
| Plan Cost-Sharing Highlights |                                                                                                                                                                                                                                                             |                                                       |
| Plan Cost-Sharing Highlights | In Network                                                                                                                                                                                                                                                  | Out of Network                                        |
| Primary Care Office Visit    | \$15 copay per visit                                                                                                                                                                                                                                        | Covered at 80%, subject to deductible                 |
| Specialist Office Visit      | \$40 copay per visit                                                                                                                                                                                                                                        | Covered at 80%, subject to deductible                 |
| Coinsurance                  | None                                                                                                                                                                                                                                                        | Covered at 80%                                        |
| Deductible                   | None                                                                                                                                                                                                                                                        | Out-of-Network: \$5,000 Individual / \$10,000 Family  |
| Out-of-Pocket Maximum        | In-Network: \$5,500 Individual / \$11,000 Family                                                                                                                                                                                                            | Out-of-Network: \$10,000 Individual / \$20,000 Family |

| SimplyBlue Plus Platinum 2          |                                                                                                                 |                                       |
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| Lifetime Maximum                    | None                                                                                                            | None                                  |
| <b>Plan Benefits</b>                |                                                                                                                 |                                       |
| Preventive Healthcare Services      | In Network                                                                                                      | Out of Network                        |
| Well child visits                   | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Adult Routine physical exams        | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Adult Immunizations                 | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Mammography                         | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Pap Smear                           | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Routine GYN Exam                    | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Prostate cancer screening           | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Colonoscopy                         | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Family Planning Services            | Covered in Full                                                                                                 | Covered at 80%, subject to deductible |
| Physician Office Services           | In Network                                                                                                      | Out of Network                        |
| Diagnostic Visits                   | \$15 PCP copay; \$40 Specialist copay per visit                                                                 | Covered at 80%, subject to deductible |
| Telemedicine Program                | Acute and Behavioral Health, & Digital Physical Therapy Covered in Full<br>Teledermatology \$40 copay per visit | Not Covered                           |
| Diagnostic x-rays                   | \$40 copay per visit                                                                                            | Covered at 80%, subject to deductible |
| Advanced Imaging Services           | \$100 copay per visit                                                                                           | Covered at 80%, subject to deductible |
| Diagnostic Laboratory and pathology | \$40 copay per visit                                                                                            | Covered at 80%, subject to deductible |
| Allergy tests                       | \$15 PCP copay; \$40 Specialist copay per visit                                                                 | Covered at 80%, subject to deductible |
| Allergy injections                  | \$15 PCP copay; \$40 Specialist copay per visit                                                                 | Covered at 80%, subject to deductible |
| Chemotherapy                        | \$15 copay per visit                                                                                            | Covered at 80%, subject to deductible |
| Radiation therapy                   | \$40 copay per visit                                                                                            | Covered at 80%, subject to deductible |
| Maternity Services                  | In Network                                                                                                      | Out of Network                        |
| Prenatal care                       | Covered in Full (Cost share may apply to ultrasounds, lab work and sick visits)                                 | Covered at 80%, subject to deductible |

|                                            | <b>SimplyBlue Plus Platinum 2</b>                                          |                                                                                           |
|--------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Hospital care for mom (including delivery) | Subject to \$500 copay per admission                                       | Covered at 80% per admission, subject to deductible                                       |
| Newborn nursery care                       | Covered in Full                                                            | Covered at 80%, subject to deductible                                                     |
| Prescription Drug                          | In Network                                                                 | Out of Network                                                                            |
| Prescription Drug Coverage                 | \$10/\$35/\$70<br>\$0 generics for kids up to age 19                       | Not Covered                                                                               |
| Diabetic drugs, insulin, and supplies      | \$15 copay per 30 day supply<br>Insulin: Covered in full                   | Covered at 80%, subject to deductible                                                     |
| Inpatient Hospital Benefits                | In Network                                                                 | Out of Network                                                                            |
| Hospital benefits                          | Subject to \$500 copay per admission for unlimited days                    | Covered at 80% per admission for unlimited days, subject to deductible                    |
| Physician visits in the hospital           | Covered in Full                                                            | Covered at 80%, subject to deductible                                                     |
| Inpatient physical rehabilitation          | Subject to \$500 copay per admission for up to 60 day(s) per contract year | Covered at 80% per admission for up to 60 day(s) per contract year, subject to deductible |
| Surgery                                    | Covered in Full                                                            | Covered at 80%, subject to deductible                                                     |
| Anesthesia                                 | Covered in Full                                                            | Covered at 80%, subject to deductible                                                     |
| Emergency Care                             | In Network                                                                 | Out of Network                                                                            |
| Emergency room care                        | \$300 copay per visit                                                      | \$300 copay per visit                                                                     |
| Freestanding urgent care center            | \$40 copay per visit                                                       | Covered at 80%, subject to deductible                                                     |
| Ambulance                                  | \$300 copay per visit                                                      | \$300 copay per visit                                                                     |
| Outpatient Hospital Benefits               | In Network                                                                 | Out of Network                                                                            |
| Diagnostic x-rays                          | \$40 copay per visit                                                       | Covered at 80%, subject to deductible                                                     |
| Advanced Imaging Services                  | \$100 copay per visit                                                      | Covered at 80%, subject to deductible                                                     |
| Diagnostic Laboratory and pathology        | \$40 copay per visit                                                       | Covered at 80%, subject to deductible                                                     |
| Surgical Care Facility Fee                 | \$300 copay per visit                                                      | Covered at 80%, subject to deductible                                                     |
| Chemotherapy                               | \$15 copay per visit                                                       | Covered at 80%, subject to deductible                                                     |
| Radiation Therapy                          | \$40 copay per visit                                                       | Covered at 80%, subject to deductible                                                     |
| Mental Health and Substance Use            | In Network                                                                 | Out of Network                                                                            |

| <b>SimplyBlue Plus Platinum 2</b> |                                                                                                          |                                                                                                                           |
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| Inpatient mental health care      | Subject to \$500 copay per admission for unlimited days                                                  | Covered at 80% per admission for unlimited days, subject to deductible                                                    |
| Outpatient mental health care     | Covered in Full                                                                                          | Covered at 80%, subject to deductible                                                                                     |
| Inpatient substance use           | Subject to \$500 copay per admission for unlimited days                                                  | Covered at 80% per admission for unlimited days, subject to deductible                                                    |
| Outpatient substance use          | Covered in Full                                                                                          | Covered at 80%, subject to deductible                                                                                     |
| <b>Other Services</b>             | <b>In Network</b>                                                                                        | <b>Out of Network</b>                                                                                                     |
| Skilled nursing facility          | Subject to \$500 copay per admission for up to 200 day(s) per year                                       | Covered at 80%, per admission for up to 200 day(s) per year, subject to deductible                                        |
| Home care                         | \$15 copay per visit for 40 visits per year                                                              | Covered at 80% for 40 visits per year, subject to deductible                                                              |
| Hospice                           | Subject to \$500 copay per admission for up to 210 day(s) per year                                       | Covered at 80%, per admission for up to 210 day(s) per year, subject to deductible                                        |
| Outpatient Therapy                | \$15 copay per visit for physical, speech and occupational therapy for up to 60 visits per contract year | Covered at 80% for physical, speech and occupational therapy for up to 60 visits per contract year, subject to deductible |
| Durable medical equipment         | Covered at 50%                                                                                           | Covered at 50%, subject to deductible                                                                                     |
| External prosthetics              | Covered at 50%                                                                                           | Covered at 50%, subject to deductible                                                                                     |
| Chiropractic                      | \$15 copay per visit                                                                                     | Covered at 80%, subject to deductible                                                                                     |
| Acupuncture                       | \$15 copay per visit<br>10 visit per benefit period                                                      | Covered at 80%, subject to deductible<br>10 visit per benefit period                                                      |
| Hearing Aids                      | Covered at 50% for a single purchase once every 3 years                                                  | Covered at 50%, subject to deductible for a single purchase once every 3 years                                            |
| <b>Vision Benefits</b>            | <b>In Network</b>                                                                                        | <b>Out of Network</b>                                                                                                     |
| Adult Routine Vision Exam         | One routine exam covered in full per year                                                                | Covered at 80% for one routine exam every year, subject to the deductible                                                 |
| Adult Diagnostic Vision           | \$40 copay per visit                                                                                     | Covered at 80%, subject to deductible                                                                                     |
| Adult Eyewear                     | Eyewear Reimbursement of \$100 per year                                                                  | Eyewear Reimbursement of \$100 per year                                                                                   |
| Pediatric Routine Vision Exam     | One routine exam covered in full per year                                                                | Covered at 80% for one routine exam every year, subject to the deductible                                                 |

|                                             | <b>SimplyBlue Plus Platinum 2</b>                                                                                     |                                                                                                                                       |
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| Pediatric Eyewear                           | Covered at 50% one purchase per plan year                                                                             | Covered at 50%, subject to deductible one purchase per plan year                                                                      |
| Dental Benefits                             | In Network                                                                                                            | Out of Network                                                                                                                        |
| Adult Dental Care                           | Not Covered                                                                                                           | Not Covered                                                                                                                           |
| Pediatric Dental: Preventive & Routine      | Not Covered                                                                                                           | Not Covered                                                                                                                           |
| Pediatric Major Dental Care & Medical Ortho | Not Covered                                                                                                           | Not Covered                                                                                                                           |
| Accidental Dental - Outpatient Surgical     | \$300 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly | Covered at 80% for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to deductible |

**This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.**

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