Schedule of Benefits

Notes:

- Copayments (Copay) - The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider. The Copayment amount does not count towards the Deductible.
- Single Highest Copay applies when multiple services that are subject to individual Copayments are performed on the same day by the same Network Provider. Please check your Summary Plan Description for details.
- This Summary Plan Description (SPD) does not provide coverage when you use an Out-of-Network Provider, except for an Emergency.
- Some benefits may require Preauthorization. Please check your Summary Plan Description for details.
- Please read the entire Summary Plan Description for other Covered Services, Benefits, Exclusions, & Limitations.
- Benefits are applied per Calendar Year.
- This Summary Plan Description does not cover Acupuncture, Cosmetic Surgery, dental or routine eye care (adult), Infertility treatment, long term care, weight loss programs, or non- emergency care when traveling outside the United States.
- In-Network Benefits are paid based on the Negotiated Rate.
- The Emergency Room Service Copayment does not count toward satisfying the Deductible.

2026 Schedule of Benefits – Select 4000 HSA HMO		
Annual	**Network Provider**	**Out-of-Network Provider**
Individual Deductible:	$4,000	N/A
Family Deductible:	$8,000	N/A
Individual Out-of-Pocket Maximum:	$6,300	N/A
Family Out-of-Pocket Maximum:	$12,600	N/A
Coinsurance:	20%	N/A
Payment Order:	Copayment applies first (if applicable), then Deductible, then Coinsurance (if applicable).Copayment counts toward Maximum Out-of-Pocket amount.	

Schedule of Benefits				
Common Medical Event	**Services You May Need**	**Network Provider**	**Out-of-Network Provider**	**Exclusions & Limitations and Other Important Information**
If you visit a health care Provider's office or clinic	Primary care visit to treat an Illness or Injury	20% Coinsurance Deductible applies first	Not covered	None

If you visit a health care Provider's office or clinic	Specialist visit	20% Coinsurance Deductible applies first	Not covered	None
	Preventive care/screening/ Immunizations	No charge Deductible does not apply	Not covered	For Children under the age of 6: required Immunizations are not subject to Deductible, Copayment, or Coinsurance requirements for Network Providers. You may have to pay for services that aren't preventive. Ask your Provider if the services needed are preventive. Then check what Your Plan will pay for.
If you have a test	Diagnostic tests – Blood work	20% Coinsurance Deductible applies first	Not covered	Professional/ interpretation service is included in diagnostic blood work and x-ray Cost Share. Preauthorization required for all genetic testing and complex imaging.
	Diagnostic tests - X-rays	20% Coinsurance Deductible applies first	Not covered	
	Imaging (CT/PET scans, MRIs)	20% Coinsurance Deductible applies first	Not covered	
If you need immediate medical attention	Emergency room services	20% Coinsurance Deductible applies first		None
	Emergency medical transportation	20% Coinsurance Deductible applies first		None
	Urgent Care	20% Coinsurance Deductible applies first		None
If you have a Hospital stay	Facility fee (e.g., Hospital room)	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Physician/surgeon fees	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.

If you have Outpatient Surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Physician/surgeon fees	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Professional Office Visits	20% Coinsurance Deductible applies first	Not covered	Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.
	Outpatient services	20% Coinsurance Deductible applies first	Not covered	
	Inpatient services	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
If you are pregnant	Office visits	20% Coinsurance Deductible applies first	Not covered	Preauthorization required for Inpatient stay that exceeds the 48/96-hour timeframe as outlined in the Summary Plan Description (SPD). Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% Coinsurance Deductible applies first	Not covered	
	Childbirth/delivery facility services	20% Coinsurance Deductible applies first	Not covered	
Oral Contraceptives & contraceptive services and devices	All FDA approved devices - educational services & counseling	No charge Deductible does not apply	Not covered	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.
If you need help recovering or have special health needs	Home Health Care	20% Coinsurance Deductible applies first	Not covered	Limited to 60 visits per Year. Preauthorization required

If you need help recovering or have special health needs	Skilled Nursing Care	20% Coinsurance Deductible applies first	Not covered	Limited to 25 days per Year. Preauthorization required.
	Prosthetic & Orthotic devices (appliances)	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Durable Medical Equipment	20% Coinsurance Deductible applies first	Not covered	Preauthorization required for items exceeding $500.
	Hospice Service	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Hearing aids & Cochlear implants	20% Coinsurance Deductible applies first	Not covered	Hearing aids & Cochlear implants limited to one (1) pair OR one (1) implant every 36 months. Preauthorization required.
	Rehabilitation services	20% Coinsurance Deductible applies first	Not covered	PT/OT/ST/Chiro – Limited to 35 combined visits for Rehabilitation Services and 35 combined visits for Habilitation Services across physical medical services per Plan Year. Plan Limitations do not apply to Medically Necessary services or services related to Autism Spectrum Disorder. Preauthorization required for Inpatient & ABA in Cognitive Therapy. Cardio/Pulmonary Rehabilitation limited to 36 visits for Cardiac Rehab and 36 visits for Pulmonary Rehab.
	Habilitation services	20% Coinsurance Deductible applies first	Not covered	
	Physical Therapy (PT) & Occupational Therapy (OT) & Speech Therapy (ST)	20% Coinsurance Deductible applies first	Not covered	
	Chiropractic care	20% Coinsurance Deductible applies first	Not covered	
	Speech & hearing exams	20% Coinsurance Deductible applies first	Not covered	None

If your child needs dental or eye care	Children's dental checkup	Not covered	Not covered	None
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
Other professional services	Radiation & chemotherapy	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Transplant	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Routine foot care	20% Coinsurance Deductible applies first	Not covered	None
	Infusion therapy	20% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Allergy testing	20% Coinsurance Deductible applies first	Not covered	None
	Dialysis	20% Coinsurance Deductible applies first	Not covered	None
	Telehealth or Telemedicine services	$45 Copay/visit Deductible does not apply	Not covered	Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.

<table>
<tr><th colspan="5">Pharmacy Schedule of Benefits</th></tr>
<tr><th></th><th></th><th>Network Provider</th><th>Out-of-Network Provider</th><th>Exclusions & Limitations and Other Important Information</th></tr>
<tr><td rowspan="8">If you need Drugs to treat your Illness or condition</td><td rowspan="2">Generic Drugs</td><td>Retail: $4 Copay/ Prescription
Deductible applies first</td><td>Not covered</td><td rowspan="8">Retail covers 30-day supply and mail order covers up to 90-day supply unless stated by the Formulary or the Plan Benefits.
Network Provider Prescription Drug Copayment applies to the Out-of-Pocket Maximum.
Member responsible for paying applicable Copay, allowable Claim amount, or the contracted rate of the Prescription, if less than the established Copay.
Prior Authorization is required for some Drugs.
Some Prescription Drugs and/or medications are not available through the mail order service.
Some Specialty Drugs are subject to Utilization Review or Prior Authorization.
30-day supply only; 90-day mail order not covered.</td></tr>
<tr><td>Mail order: $8 Copay/ Prescription
Deductible applies first</td><td>Not covered</td></tr>
<tr><td rowspan="2">Preferred Brand Drugs</td><td>Retail: $45 Copay/ Prescription
Deductible applies first</td><td>Not covered</td></tr>
<tr><td>Mail order: $90 Copay/ Prescription
Deductible applies first</td><td>Not covered</td></tr>
<tr><td rowspan="2">Non-Preferred Brands / Drugs</td><td>Retail: $95 Copay/ Prescription
Deductible applies first</td><td>Not covered</td></tr>
<tr><td>Mail order: $190 Copay/ Prescription
Deductible applies first</td><td>Not covered</td></tr>
<tr><td rowspan="2">Specialty Drugs</td><td>33% Coinsurance
Deductible applies first</td><td>Not covered</td></tr>
<tr><td>Mail order: Not covered</td><td>Not covered</td></tr>
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