

## 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.
- If an Out-of-Network provider charges more than the Allowed Amount, You may have to pay the difference.
- 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.

| <b>2026 Schedule of Benefits – Select 5000 HSA PPO</b> |                                                                                                                                                   |                                |
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| <b>Annual</b>                                          | <b>Network Provider</b>                                                                                                                           | <b>Out-of-Network Provider</b> |
| Individual Deductible:                                 | \$5,000                                                                                                                                           | \$10,000                       |
| Family Deductible:                                     | \$10,000                                                                                                                                          | \$20,000                       |
| Individual Out-of-Pocket Maximum:                      | \$6,300                                                                                                                                           | \$15,000                       |
| Family Out-of-Pocket Maximum:                          | \$12,600                                                                                                                                          | \$30,000                       |
| Coinsurance:                                           | 0%                                                                                                                                                | 30%                            |
| Payment Order:                                         | Copayment applies first (if applicable), then Deductible, then Coinsurance (if applicable). Copayment counts toward Maximum Out-of-Pocket amount. |                                |

| <b>Schedule of Benefits</b>                            |                                                  |                                       |                                             |                                                                     |
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| <b>Common Medical Event</b>                            | <b>Services You May Need</b>                     | <b>Network Provider</b>               | <b>Out-of-Network Provider</b>              | <b>Exclusions &amp; Limitations and Other Important Information</b> |
| If you visit a health care Provider's office or clinic | Primary care visit to treat an Illness or Injury | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | None                                                                |

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| If you visit a health care Provider's office or clinic | Specialist visit                        | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | None                                                                                                                                                                                                                                                                                                                  |
|                                                        | Preventive care/screening/Immunizations | No charge<br>Deductible does not apply | 30% Coinsurance<br>Deductible applies first | For Children under the age of 6: required Immunizations are not subject to Deductible, Copayment, or Coinsurance requirements for Network Providers.<br><br>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           | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Professional/interpretation service is included in diagnostic blood work and x-ray Cost Share.<br>Preauthorization required for all genetic testing and complex imaging.                                                                                                                                              |
|                                                        | Diagnostic tests - X-rays               | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                       |
|                                                        | Imaging (CT/PET scans, MRIs)            | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                       |
| If you need immediate medical attention                | Emergency room services                 | No charge<br>Deductible applies first  |                                             | None                                                                                                                                                                                                                                                                                                                  |
|                                                        | Emergency medical transportation        | No charge<br>Deductible applies first  |                                             | None                                                                                                                                                                                                                                                                                                                  |
|                                                        | Urgent Care                             | No charge<br>Deductible applies first  |                                             | None                                                                                                                                                                                                                                                                                                                  |
| If you have a Hospital stay                            | Facility fee (e.g., Hospital room)      | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                            |
|                                                        | Physician/surgeon fees                  | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                            |

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| If you have Outpatient Surgery                                            | Facility fee (e.g., ambulatory surgery center)               | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                                       | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Professional Office Visits                                   | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.                                                                                                                                                                                                                                                         |
|                                                                           | Outpatient services                                          | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | Inpatient services                                           | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                                                                                              |
| If you are pregnant                                                       | Office visits                                                | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Preauthorization required for Inpatient stay that exceeds the 48/96-hour timeframe as outlined in the Summary Plan Description (SPD).<br><br>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                    | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services                        | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                         |
| Oral Contraceptives & contraceptive services and devices                  | All FDA approved devices - educational services & counseling | No charge<br>Deductible does not apply | 30% Coinsurance<br>Deductible applies first | 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                                             | No charge<br>Deductible applies first  | 30% Coinsurance<br>Deductible applies first | Limited to 60 visits per Year.<br>Preauthorization required                                                                                                                                                                                                                                                                                                                             |

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| If you need help recovering or have special health needs | Skilled Nursing Care                                                    | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | Limited to 25 days per Year.<br>Preauthorization required.                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                          | Prosthetic & Orthotic devices (appliances)                              | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                          | Durable Medical Equipment                                               | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | Preauthorization required for items exceeding \$500.                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                          | Hospice Service                                                         | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                          | Hearing aids & Cochlear implants                                        | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | Hearing aids & Cochlear implants limited to one (1) pair OR one (1) implant every 36 months.<br>Preauthorization required.                                                                                                                                                                                                                                                                                                                                                             |
|                                                          | Rehabilitation services                                                 | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | 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.<br><br>Preauthorization required for Inpatient & ABA in Cognitive Therapy.<br><br>Cardio/Pulmonary Rehabilitation limited to 36 visits for Cardiac Rehab and 36 visits for Pulmonary Rehab. |
|                                                          | Habilitation services                                                   | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                          | Physical Therapy (PT) & Occupational Therapy (OT) & Speech Therapy (ST) | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                          | Chiropractic care                                                       | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                          | Speech & hearing exams                                                  | No charge<br>Deductible applies first | 30% Coinsurance<br>Deductible applies first | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| 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            | No charge<br>Deductible applies first         | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                          |
|                                        | Transplant                          | No charge<br>Deductible applies first         | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                          |
|                                        | Routine foot care                   | No charge<br>Deductible applies first         | 30% Coinsurance<br>Deductible applies first | None                                                                                                                                                |
|                                        | Infusion therapy                    | No charge<br>Deductible applies first         | 30% Coinsurance<br>Deductible applies first | Preauthorization required.                                                                                                                          |
|                                        | Allergy testing                     | No charge<br>Deductible applies first         | 30% Coinsurance<br>Deductible applies first | None                                                                                                                                                |
|                                        | Dialysis                            | No charge<br>Deductible applies first         | 30% Coinsurance<br>Deductible applies first | None                                                                                                                                                |
|                                        | Telehealth or Telemedicine services | \$45 Copay/visit<br>Deductible does not apply | 30% Coinsurance<br>Deductible applies first | Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation. |

| Pharmacy Schedule of Benefits                        |                              |                                                                      |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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|                                                      |                              | Network Provider                                                     | Out-of-Network Provider                     | Exclusions & Limitations and Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need Drugs to treat your Illness or condition | Generic Drugs                | Retail: \$4 Copay/<br>Prescription<br>Deductible applies first       | 50% Coinsurance<br>Deductible applies first | <p>Retail covers 30-day supply and mail order covers up to 90-day supply unless stated by the Formulary or the Plan Benefits.</p> <p>Network Provider Prescription Drug Copayment applies to the Out-of-Pocket Maximum.</p> <p>Member responsible for paying applicable Copay, allowable Claim amount, or the contracted rate of the Prescription, if less than the established Copay.</p> <p>Prior Authorization is required for some Drugs.</p> <p>Some Prescription Drugs and/or medications are not available through the mail order service.</p> <p>Some Specialty Drugs are subject to Utilization Review or Prior Authorization.</p> <p>30-day supply only; 90-day mail order not covered.</p> |
|                                                      |                              | Mail order: \$8 Copay/<br>Prescription<br>Deductible applies first   | Mail order:<br>Not covered                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                      | Preferred Brand Drugs        | Retail: \$45 Copay/<br>Prescription<br>Deductible applies first      | 50% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                      |                              | Mail order: \$90 Copay/<br>Prescription<br>Deductible applies first  | Mail order:<br>Not covered                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                      | Non-Preferred Brands / Drugs | Retail: \$95 Copay/<br>Prescription<br>Deductible applies first      | 50% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                      |                              | Mail order: \$190 Copay/<br>Prescription<br>Deductible applies first | Mail order:<br>Not covered                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                      | Specialty Drugs              | 33% Coinsurance<br>Deductible applies first                          | 50% Coinsurance<br>Deductible applies first |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                      |                              | Mail order: Not covered                                              | Mail order:<br>Not covered                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |