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.
- Copayment charges in any Calendar Year will not exceed 50% of the total cost of services provided, or 200% of the total annual Premium cost in that Year, provided the Member demonstrates that Copayments in that amount have been paid in that Year.
- 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 Evidence of Coverage for details.
- This Evidence of Coverage (EOC) does not provide coverage when you use an Out-of-Network Provider, except for an Emergency.
- Some benefits may require Preauthorization. Please check your Evidence of Coverage for details.
- Please read the entire Evidence of Coverage for other Covered Services, Benefits, Exclusions, & Limitations.
- Benefits are applied per Calendar Year.
- This Evidence of Coverage does not cover 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.

2026 Schedule of Benefits – Select 001 HMO		
Annual	**Network Provider**	**Out-of-Network Provider**
Individual Out-of-Pocket Maximum:	$6,600	N/A
Family Out-of-Pocket Maximum:	$13,200	N/A
Coinsurance:	0%	N/A
Payment Order:	The Copayment counts toward Out-of-Pocket Maximum.	

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	$30 Copay/visit	Not covered	None

If you visit a health care Provider's office or clinic	Specialist visit	$55 Copay/visit	Not covered	None
	Preventive care/screening/ Immunizations	No charge	Not covered	For Children under the age of 6: required Immunizations are not subject to Copayment, 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	No charge	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	No charge	Not covered	
	Imaging (CT/PET scans, MRIs)	$250 Copay/visit	Not covered	
If you need immediate medical attention	Emergency room services	$400 Copay/visit		Copayment waived if admitted.
	Emergency medical transportation	$350 Copay/trip		None
	Urgent Care	$55 Copay/visit		None
If you have a Hospital stay	Facility fee (e.g., Hospital room)	$350 Copay/day for the first 3 days	Not covered	Preauthorization required.
	Physician/surgeon fees	No charge	Not covered	Cost included in Inpatient stay.

If you have Outpatient Surgery	Facility fee (e.g., ambulatory surgery center)	Hospital - $350 Copay/visit Freestanding clinic - $350 Copay/visit	Not covered	Preauthorization required.
	Physician/surgeon fees	No charge	Not covered	Cost included in Outpatient facility fee. Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Professional Office Visits	$30 Copay/visit	Not covered	Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.
	Outpatient services	No charge	Not covered	
	Inpatient services	$350 Copay/day for the first 3 days of admission	Not covered	Preauthorization required
If you are pregnant	Office visits	$30 Copay/visit	Not covered	Preauthorization required for Inpatient stay that exceeds the 48/96-hour timeframe as outlined in the Evidence of Coverage (EOC). Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment, may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$350 Copay/day for the first 3 days of admission	Not covered	
Oral Contraceptives & contraceptive services and devices	All FDA approved devices - educational services & counseling	No charge	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	$55 Copay/visit	Not covered	Limited to 60 visits per Year. Preauthorization required

If you need help recovering or have special health needs	Skilled Nursing Care	$350 Copay/day for the first 3 days of admission	Not covered	Limited to 25 days per Year. Preauthorization required.
	Prosthetic & Orthotic devices (appliances)	No charge	Not covered	Preauthorization required.
	Durable Medical Equipment	No charge	Not covered	Limited to Plan requirements. Preauthorization required for items exceeding $500.
	Hospice Service	No charge	Not covered	Preauthorization required.
	Hearing aids & Cochlear implants	No charge	Not covered	Hearing aids & Cochlear implants limited to one (1) pair OR one (1) implant every 36 months. Preauthorization required.
	Rehabilitation services	No charge	Not covered	Preauthorization required for Inpatient & ABA in cognitive therapy.
	Habilitation services	No charge	Not covered	
	Physical Therapy (PT) & Occupational Therapy (OT) & Speech Therapy (ST)	$30 Copay/visit	Not covered	
	Chiropractic care	$30 Copay/visit	Not covered	Limited to 10 visits per Plan Year.
	Speech & hearing exams	$30 Copay/visit	Not covered	None
	Acupuncture	$30 Copay/visit	Not covered	Limited to 20 visits per Plan Year, one (1) per day.

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	$25 Copay/visit	Not covered	Preauthorization required.
	Transplant	No charge	Not covered	Preauthorization required.
	Routine foot care	No charge	Not covered	None
	Infusion therapy	No charge	Not covered	Preauthorization required.
	Allergy testing	No charge	Not covered	None
	Dialysis	No charge	Not covered	None
	Telehealth or Telemedicine services	No charge	Not covered	Copayment, amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.

Pharmacy Schedule of Benefits				
		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/ Prescription	Not covered	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. Cost Sharing for insulin on the formulary will not exceed $25 per prescription for a 30-day supply. 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.
		Mail order: $8 Copay/ Prescription	Not covered	
	Preferred Brand Drugs	Retail: $45 Copay/ Prescription	Not covered	
		Mail order: $80 Copay/ Prescription	Not covered	
	Non-Preferred Brands / Drugs	Retail: $75 Copay/ Prescription	Not covered	
		Mail order: $150 Copay/ Prescription	Not covered	
	Specialty Drugs	33% Coinsurance	Not covered	
		Mail order: Not covered	Not covered	