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 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.
- The Emergency Room Service Copayment does not count toward satisfying the Deductible.

2026 Schedule of Benefits – Select 6600-100 Standard HMO		
Annual	**Network Provider**	**Out-of-Network Provider**
Individual Deductible:	$6,600	N/A
Family Deductible:	$13,200	N/A
Individual Out-of-Pocket Maximum:	$6,600	N/A
Family Out-of-Pocket Maximum:	$13,200	N/A
Coinsurance:	0%	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	$35 Copay/visit Deductible does not apply	Not covered	None

If you visit a health care Provider's office or clinic	Specialist visit	$70 Copay/visit Deductible does not apply	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	$25 Copay/visit Deductible does not apply	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	$50 Copay/visit Deductible does not apply	Not covered	
	Imaging (CT/PET scans, MRIs)	$150 Copay/visit Deductible does not apply	Not covered	
If you need immediate medical attention	Emergency room services	$400 Copay/visit Deductible does not apply		Copayment waived if admitted.
	Emergency medical transportation	No charge Deductible applies first		None
	Urgent Care	$50 Copay/visit Deductible does not apply		None
If you have a Hospital stay	Facility fee (e.g., Hospital room)	No charge Deductible applies first	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 - No charge Deductible applies first Freestanding clinic - $300 Copay/visit Deductible does not apply	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	$35 Copay/visit Deductible does not apply	Not covered	Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.
	Outpatient services	No charge Deductible does not apply	Not covered	
	Inpatient services	No charge Deductible applies first	Not covered	Preauthorization required.
If you are pregnant	Office visits	$35 Copay/visit Deductible applies first	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, 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	Not covered	
	Childbirth/delivery facility services	No charge 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	No charge 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	No charge Deductible applies first	Not covered	Limited to 25 days per Year. Preauthorization required.
	Prosthetic & Orthotic devices (appliances)	No charge Deductible applies first	Not covered	Preauthorization required.
	Durable Medical Equipment	No charge Deductible applies first	Not covered	Limited to Plan requirements. Preauthorization required for items exceeding $500.
	Hospice Service	No charge Deductible applies first	Not covered	Preauthorization required.
	Hearing aids & Cochlear implants	No charge 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	No charge Deductible applies first	Not covered	Physical therapy (PT)/occupational therapy (OT)/speech therapy (ST): Limited to 60 combined visits/year; and 1 visit per day. Chiropractic limited to 10 visits/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.
	Habilitation services	No charge Deductible applies first	Not covered	
	Physical Therapy (PT) & Occupational Therapy (OT) & Speech Therapy (ST)	$35 Copay/visit Deductible does not apply	Not covered	
	Chiropractic care	$35 Copay/visit Deductible does not apply	Not covered	
	Speech & hearing exams	$35 Copay/visit Deductible does not apply	Not covered	None
	Acupuncture	$35 Copay/visit Deductible does not apply	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 Deductible does not apply	Not covered	Preauthorization required.
	Transplant	No charge Deductible applies first	Not covered	Preauthorization required.
	Routine foot care	No charge Deductible applies first	Not covered	None
	Infusion therapy	No charge Deductible applies first	Not covered	Preauthorization required.
	Allergy testing	No charge Deductible applies first	Not covered	None
	Dialysis	No charge Deductible applies first	Not covered	None
	Telehealth or Telemedicine services	No charge 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.

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 Deductible does not apply	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 Deductible does not apply	Not covered	
	Preferred Brand Drugs	Retail: $40 Copay/ Prescription Deductible does not apply	Not covered	
		Mail order: $80 Copay/ Prescription Deductible does not apply	Not covered	
	Non-Preferred Brands / Drugs	Retail: $75 Copay/ Prescription Deductible does not apply	Not covered	
		Mail order: $150 Copay/ Prescription Deductible does not apply	Not covered	
	Specialty Drugs	33% Coinsurance Deductible does not apply	Not covered	
		Mail order: Not covered	Not covered	