SCHEDULE OF MEDICAL BENEFITS
for
[Pinpoint Bronze]
Effective: January 1, 2026

ELIGIBILE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS/LIMITATIONS AND THE MAXIMUM ALLOWABLE CHARGE

TIER 1 Providers with Reference Based Pricing
for all other providers

Summary of Benefits	Amounts Participants are Responsible For:	
	TIER I **Preferred Providers; Hospitals; and Facilities**	**TIER II** **Non-preferred Providers; Hospitals; and Facilities**
Calendar Year Deductible[1*]		
Per Individual Per Calendar Year	$0	$4000
Per Family Per Calendar Year	$0	$8000
Out-of-Pocket Maximum (OPM)[2*] *(Included Calendar Year Deductible, most Med Co-Ins, Copays)*		
For Individual Per Calendar Year	None	$8000
For Family Per Calendar Year	None	$16000
Coinsurance	0% coinsurance	30% Coinsurance after Deductible
Individual Annual Maximum	None	
Lifetime Limits on Essential Benefits	Unlimited	
Annual Limits on Essential Benefits	None	
Copays *(Per visit unless otherwise noted)*		
Telemedicine	$0	$40 Copay after Deductible
Office Visits to PCP	$10 Copay	$40 Copay after Deductible
Specialist Office Visits	$20 Copay	$50 Copay after Deductible
Durable Medical Equipment (DME)	$30 Copay	30% Coinsurance after Deductible
Urgent Care	$30 Copay	30% Coinsurance after Deductible
Emergency Room	$100 Copay	30% Coinsurance after Deductible
Hospital Inpatient	$0 Copay	30% Coinsurance after Deductible
Hospital Outpatient	$0 Copay	30% Coinsurance after Deductible

***Please see footnotes on page 9.**

Summary of Benefits	Amounts Participants are Responsible For:	
	TIER I **Preferred Providers; Hospitals; and Facilities**	**TIER II** **Non-preferred Providers; Hospitals; and Facilities**
Preventative Care		
Routine Adult Physical Exams/Immunizations *1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.*	0%	$40 Copay after Deductible
Routine Well Child Services – Up to age 18 Well-Child Office Visit *(Includes routine exams, immunizations, developmental assessments, and lab services.)*	0%	$40 Copay after Deductible
Routine Gynecological Care Exams *Recommended: One exam per calendar year. Includes routine tests and related lab fees.*	0%	$40 Copay after Deductible
Routine Mammograms *(Age 35-39 – One baseline mammogram* *Age 40-49 – One mammogram every two years* *Age 50+ - One mammogram every year as ordered upon recommendation of physician based upon family history.)*	0%	$40 Copay after Deductible
Women's Health *Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.*	0%	$40 Copay after Deductible
Bone Density	0%	$50 Copay after Deductible
Colorectal Cancer Screening/Colonoscopy *(One stool test for blood every 5 years beginning at age 50. Colonoscopy every 10 years beginning at age 50. Double contrast barium enema every 5 years beginning at age 50, as ordered upon recommendation of physician based upon family history.)*	0%	30% Coinsurance after Deductible
Nutritional Counseling	0%	$50 Copay after Deductible
Routine Eye Exams *Pediatric eye exam only - 1 routine exam per 12 months.*	0%	$50 Copay after Deductible
Routine Hearing Screenings	0%	$50 Copay after Deductible
Smoking Cessation *(Eligible services include stop-smoking counseling services and related medical evaluations. Limited to 2 programs per lifetime per person.)*	0%	$50 Copay after Deductible
X-Rays/Labs *(Preventative care)*	0%	$50 Copay after Deductible

Summary of Benefits	Amounts Participants are Responsible For:	
	TIER I Preferred Providers; Hospitals; and Facilities	**TIER II Non-preferred Providers; Hospitals; and Facilities**
Allergy Testing		
Allergy Testing, Serum, and Antigen	$10 Copay	$40 Copay after Deductible
Allergy Service/Injections/Injection Specialists	$10 Copay	$40 Copay after Deductible
Other Outpatient Facilities	$100 Copay	30% Coinsurance after Deductible
Anesthesia		
Inpatient	$20 Copay	30% Coinsurance after Deductible
Outpatient	$20 Copay	30% Coinsurance after Deductible
Birthing Centers	0% Coinsurance, $0 Deductible	30% Coinsurance after Deductible
Chemotherapy/Radiation Therapy/IV Therapy* *(Includes treatment and supplies.)*		
Physician's Office	$20 Copay	$200 Copay after Deductible
Outpatient Facility	$100 Copay	30% Coinsurance after Deductible
Hospital	$100 Copay	30% Coinsurance after Deductible
Chiropractic Care* *(more than 8 visits per year requires pre-authorization)*	$20 Copay	$50 Copay after Deductible
Contraceptives *(other than covered by Rx plan)*	$30 Copay	$75 Copay after Deductible
Diabetes Care Benefits (Diabetes Self-Management Benefits)		
Office Services	$20 Copay	$40 Copay after Deductible
Specialist Office Services	$20 Copay	$40 Copay after Deductible
Outpatient Clinic	$30 Copay	$75 Copay after Deductible
Inpatient	$100 Copay	30% Coinsurance after Deductible
Diagnostic X-Ray and Lab Services/Tests		
Lab Tests (physician's office)	$20 Copay	$40 Copay after Deductible
Lab Tests (outpatient testing not in physician's office)	$20 Copay	$40 Copay after Deductible
CT/MRI/PET & other high-tech imaging* *(Pre-certification required)*	$30 Copay	$75 Copay after Deductible
Diagnostic X-Rays	$20 Copay	$50 Copay after Deductible
Dialysis Services		
Inpatient	$100 Copay	30% Coinsurance after Deductible
Outpatient	$100 Copay	30% Coinsurance after Deductible

*Requires pre-certification through Edison Health Solutions (888) 562-4784. Member, patient or provider MUST CALL. See pre-certification requirements listed at the end of this Benefit Summary.

Summary of Benefits	Amounts Participants are Responsible For:	
	TIER I Preferred Providers; Hospitals; and Facilities	**TIER II Non-preferred Providers; Hospitals; and Facilities**
Dental		
Accidental Injury *(Emergency treatment of dental injury, subject to COB.)*	$100 Copay	$200 Copay after Deductible
Removal of Bony-Impacted Third Molars *(Service must be medically necessary and pre-authorized, subject to COB.)*	$100 Copay	30% Coinsurance after Deductible
Emergency Medical Care		
Urgent Care Provider	$30 Copay	$40 Copay then 10% Coinsurance
Emergency Room *(Tier I benefit includes all related charges. If admitted, copay is waived and UR/Notification is required.)*	$100 Copay	$250 Copay per visit then 30% Coinsurance
Ambulance	$0 Copay	0% Coinsurance after Deductible
Non-emergency use of Ambulance	Not Covered	Not Covered
Family Planning		
Vasectomy* *(Initial surgery only.)*	$100 Copay	30% Coinsurance after Deductible
Tubal Ligation (or equivalent) *	$100 Copay	30% Coinsurance after Deductible
Habilitation Services *(Include Speech, Physical, and Occupational Therapy)*		
Office	$20 Copay	$50 Copay after Deductible
Outpatient Short-Term Rehabilitation**	$100 Copay	30% Coinsurance after Deductible
Inpatient Hospital	$100 Copay	30% Coinsurance after Deductible
Rehabilitation Services		
Office/Outpatient	$20/$100 Copay	$40 Copay/10% Coinsurance
Facility	$30 Copay	30% Coinsurance after Deductible
Inpatient	$100 Copay	30% Coinsurance after Deductible
Hospital Care *(Ass't Surgeons are paid 20% of global surgery fee.)*		
Inpatient Coverage* *(Room and Board)*	$0 Copay	30% Coinsurance after Deductible
Inpatient Physician/Surgeon Services	$0 Copay	30% Coinsurance after Deductible
Outpatient Facility	$0 Copay	30% Coinsurance after Deductible
Surgery Facility	$30 Copay	30% Coinsurance after Deductible

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**Pre-certification by the Plan is required after the 12th visit. Please contact Edison Health Solutions (888) 562-4784. Member, patient or provider must call.

Summary of Benefits	Amounts Participants are Responsible For:	
	TIER I Preferred Providers; Hospitals; and Facilities	**TIER II Non-preferred Providers; Hospitals; and Facilities**
Ambulatory/Outpatient Surgery Facility	$30 Copay	30% Coinsurance after Deductible
Office Surgery Physician/Surgeon Services	$30 Copay	30% Coinsurance after Deductible
Outpatient Clinic Physician/Surgeon Services	$30 Copay	30% Coinsurance after Deductible
Maternity Care *(Maternity care for Dependent children is not covered.)*		
Physician Services	$20 Copay	$40 Copay after Deductible
Facility Services	$100 Copay	30% Coinsurance after Deductible
Routine Newborn Services		
Hospital	$100 Copay	30% Coinsurance after Deductible
Physician	$20 Copay	$40 Copay after Deductible
Prenatal/Postnatal Care	$20 Copay	$40 Copay after Deductible
Breast Feeding Support and Counseling	$20 Copay	$40 Copay after Deductible
Medical Supplies	$30 Copay	$100 Copay after Deductible
Mental/Behavioral Health Services		
Inpatient* *Room and Board, Inpatient Provider Visits*	$100 Copay	30% Coinsurance after Deductible
Outpatient Services* *(IOP/PHP precert at 1st visit, Outpatient/OV after the 13th visit)* *Office, Outpatient Facility, Outpatient Provider Services*	$100 Copay	30% Coinsurance after Deductible
Substance Use Disorder		
Inpatient Services* *Room and Board, Inpatient Provider Visits*	$100 Copay	30% Coinsurance after Deductible
Outpatient Services *(IOP/PHP precert at 1st visit, Outpatient/OV after the 13th visit)* *Office, Outpatient Facility, Outpatient Provider Services*	$100 Copay	30% Coinsurance after Deductible
Other Services		
Skilled Nursing Facility* *Cost sharing applies to all covered benefits incurred during inpatient stay.*	$100 Copay	30% Coinsurance after Deductible
Home Health Care*	$20 Copay	30% Coinsurance after Deductible
Hospice Care – Inpatient* *Cost sharing applies to all covered benefits incurred during inpatient stay.*	$100 Copay	30% Coinsurance after Deductible
Hospice Care – Outpatient* *Cost sharing applies to all covered benefits incurred during outpatient visit.*	$100 Copay	30% Coinsurance after Deductible
Durable Medical Equipment and Prosthetic Devices* (UR/Precert required for DME that is in excess of $1,500 or non-compliance penalty may apply.)	$30 Copay	$75 Copay after Deductible
Prosthetic Limbs	$30 Copay	$75 Copay after Deductible
Wigs (Limited to $300 per Lifetime.)	$30 Copay	$75 Copay after Deductible
Breast Pumps (Manual) (Claims Administrator determines whether to pay rental amount and length of rental or purchase price.)	$30 Copay	$75 Copay after Deductible
Organ and Tissue Transplants*	$100 Copay	30% Coinsurance after Deductible

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PRE-CERTIFICATION REQUIREMENTS	Tier I and Tier II
Member, Patient or Provider must obtain pre-treatment authorization for the following services at least 48 hours in advance: • Inpatient Admissions (including partial hospitalization and intensive out-patient programs for mental health conditions and substance abuse), other than an inpatient admission related to Emergency Services (notification only required) • Outpatient Surgery (except if performed in a physician's office) • Physical therapy, Occupational therapy, Speech therapy and Cardiac rehabilitation services that require a course of treatment of 12 or more visits • Durable Medical Equipment with a purchase price over $1500 • Home Health Care/Hospice • All Complex Imaging MRA's, MRI's, PET Scans, CT Scans • Air Ambulance • Skilled Nursing • Renal Dialysis • Chemotherapy/Radiation Therapy • Specialty Drugs and Injectables • Mental Health/Substance Abuse Out-Patient/Office after 12th visit • Transplants • I.V. Therapy • Chiropractic Care requiring more than 8 visits • Any course of treatment requiring more than 12 visits	Failure to follow pre-certification to obtain authorization will result in a reduction of: • $1000 per Hospital Admission, and/or other required precertification event. Failure to Call Edison Health Solutions (888) 562-4784 to notify of an inpatient stay related to Emergency Services will result in a reduction of: • $1000 penalty per Hospital Admission

The above is a summary of the covered benefits and cost sharing under the Plan.
In the event of a discrepancy or conflict with the provisions of the Plan Document or Summary Plan Description (SPD), those provisions shall control. Please refer to the SPD adopted by the Plan Sponsor for full descriptions of the COVERED BENEFITS, EXCLUSIONS AND LIMITATIONS OF COVERAGE.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS January 1st, 2026 – December 31st, 2026		
Coverage	**Option 1** *Dispensed through Preferred Cost Containment Program.* Member Will Pay	**Option 2** *Dispensed through In Network Retail Pharmacies* Member Will Pay
Tier 1	$0	10% of the cost of the drug up to $10
Tier 2	$0	20% of the cost of the drug up to $40
Tier 3	$0	20% of the cost of the drug up to $80

Specialty Drugs-Tier 4 **Requires Pre-Authorization** *See the Specialty Medications Pre-Authorization Process and Specialty Medication Drug Pharmacy Listing.*	
Dispensed through Preferred Cost Containment Program Member Will Pay	*Dispensed from a Non-Preferred Outlet* Member Will Pay
$0	50% of the cost of the drug up to $5000

PHARMACY PROGRAM	DRUG COUNT SUPPLY
Prescription Drug Card Retail Pharmacy Program & Specialty Drugs	Limited to 30 to 90-day supply per prescription.(1)
Mail Order/Maintenance Pharmacy Program	Limited to 90-day supply per prescription.(1)

(1)Some medications are limited to a 30-day supply by the Federal Drug Administration and require a new prescription for each 30-day supply. Mail order prescriptions for “maintenance” and “non-maintenance” medications should be written for 90-day quantities when possible and appropriate.

US-Rx

US-Rx Care Customer Service Number: 877-200-5533
Website: www.us-rxcare.com

PRESCRIPTION DRUG NOTES

1. **Many oral contraceptives and contraceptive delivery devices (e.g., birth control patches) will be paid at 100% (i.e., Copayment and Deductible waived. Please review the Zero Copay listing for the Tier exceptions also, please see the Medical portion of your Plan for further details on contraception.**
2. **Smoking Cessation Drugs and Devices:**
3. **Generic Prescription Drugs and devices used to treat smoking cessation/nicotine dependence will be paid at 100% (i.e., Copayment and Deductible waived). Please review the Zero Copay listing for the Tier exceptions.**
4. **Example of other covered drugs/supplies:**
5. **Insulin and related diabetic supplies.**
6. **Over-the-Counter (OTC) items require prescriptions. There may be a charge for OTC drugs as the list of covered drugs is limited. Please check with US-Rx Care before ordering.**
7. **Charges for specialty drugs and injectables other than the first fill at the facility providing treatment. All subsequent fills need to be Pre-Authorized and will be provided under the Pharmacy Benefits hereof.**

PRIOR AUTHORIZATION OF SPECIALTY DRUGS AND SPECIALTY PHARMACY

Prior Authorization allows US-Rx Care to verify that a specialty and/or injectable prescription drug are a part of a specific treatment plan and is medically necessary.
Prior Authorization is required for a number of specialty drugs. Visit **www.us-rxcare.com/providers/** to obtain additional Prior Authorization Specialty Drug Forms. You can review the attached US-Rx Care specialty drug list or check with your pharmacist or provider to determine whether Prior Authorization applies to the drug that has been prescribed for you.

To receive Prior Authorization for Specialty and Injectable Prescription Drugs, please follow these steps:

1. Have your doctor fill out the specialty drug prior authorization form.
2. Have your doctor submit your prescription to the designated specialty pharmacy. See Specialty Pharmacy and Drug list.
3. Once your prescription has been submitted to the specialty pharmacy, you need to call the specialty pharmacy to register you will be required to provide your billing information and delivery instructions.
4. If your drug is not on the list please contact US-Rx Care at 877-200-5533 and ask for the clinical review team. A Clinical review team member will get you the pharmacy information that fills your specific drug. Make sure you know the drug and strength.

Note: If you do not follow these instructions, fulfillment of your specialty medication may be delayed.

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[1]All covered expenses accumulate toward the Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
Pharmacy expenses do not apply toward the deductible
The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.
[2]All covered expenses, excluding prescription drugs accumulate simultaneously toward the Out of Pocket Maximum. Certain member cost sharing elements may not apply toward the Out of Pocket Maximum.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles (except any penalty amounts) may be used to satisfy the Out of Pocket Maximum.
The family Out of Pocket Maximum is a cumulative Out of Pocket Maximum for all family members. The family Out of Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out of Pocket Maximum amount.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing.