SCHEDULE OF BENEFITS – PLAN H2

Effective January 1, 2027

This plan is a High Deductible Health Plan (HDHP), designed to qualify for use with a Health Savings Account (HSA). All charges except charges for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. The plan uses the Blue Choice Select (BCS) PPO Network. (Members whose home residence is in Sangamon, Wabash, or Lawrence counties; or who reside outside the state of Illinois; or those working at a Trust participating district that has opted out of the BCS Network will use the BCBS PPO Network. If you have questions regarding your network assignment, ask your district for assistance.) To receive maximum benefits, use Network providers. You may search online at **www.bcbsil.com** to determine if your provider belongs to the BCS Network. If you use a Non-Network provider your share of costs will be higher and you may be balance billed by the provider for amounts that exceed the plan's allowed amounts. You will also be responsible for pre-certifying your services when you use Non-Network providers.

Benefits are paid subject to the deductibles, benefit percentages and maximum amounts shown below. If you have questions about your benefits, please contact BVA Customer Service at (855) 686-8517. BVA representatives are available to help you find quality PPO providers and help you understand your benefits and your share of the costs based on the plan's copays, deductibles, coinsurance, and out of pocket maximums.

Benefit Maximums		
Calendar Year Maximum Benefits	Chiropractic and Osteopathic Manipulation - $750	
Deductible and Out-of-Pocket Maximum	**Network**	**Non-Network**
Calendar Year Deductible[1] • Individual • Family	$2,150 $4,300	$4,300 $8,600
Calendar Year Out-of-Pocket[1,2] • Individual • Family	$5,550 $11,100	$11,100 $22,200

[1] If any dependents are covered, the full Family Calendar Year Deductible must be satisfied before the Plan will pay expenses for any covered family member, except expenses for preventive care. However, each individual in a family is required to contribute no more than the individual Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for that individual.

Network and Non-Network deductible and out-of-pocket amounts will accumulate separately.

[2] **The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum**:

- Spinal adjustment (chiropractic and osteopathic manipulation) charges;
- Charges for surgical procedures for morbid obesity outside the Network;
- Penalties for failure to pre-certify when required by the Plan;
- Any ineligible expenses;
- Any expenses in excess of Calendar Year Maximums.

All other Coinsurance and Calendar Year Deductibles apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum.

Description of Service	Network	Non-Network
All charges are subject to the Calendar Year Deductible unless otherwise noted.		
Inpatient Hospital Services for treatment of illness or injury (including Mental/Nervous, Alcohol and/or Substance Abuse)	75%	55%
Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)	75%	55%
The charges of certain providers will be considered at the same benefit level as the hospital facility in which services are rendered. This benefit applies only to the following inpatient or outpatient hospital facility charges: (1) Inpatient hospital professional fees for radiology, pathology or anesthesiology; (2) Outpatient hospital professional fees for radiology, pathology or anesthesiology.		
Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation.	75%	75%
Non-Network Emergency Room treatment will be subject to the Network Out-of-Pocket Maximum.		
Urgent Care Center/Facility or Physician	75%	75%
Medically Necessary Ambulance Transportation	80%	80%
Non-Network Medically Necessary Ambulance Expenses will be subject to the Network Out-of-Pocket Maximum.		
Pre-admission Testing	75%	55%
Physician's Inpatient Visits (includes Medical, Surgical, Mental/Nervous, Alcohol and/or Substance Abuse visits)	75%	55%
Second Surgical Opinion	75%	55%
Diagnostic Laboratory Expenses (Other than Independent Lab)	75%	55%
Diagnostic Laboratory Expenses (Independent Lab)	100%	55%
Diagnostic Laboratory Expenses - When a covered member uses the services of a Network Independent Lab provider, after satisfaction of the calendar year deductible, there will be no out-of-pocket expense to the member and covered services will be covered at 100%.		
Diagnostic Mammogram	100%	55%
Diagnostic Imaging (X-ray, CT scan, MRI)	75%	55%
Organ and Tissue Transplants	75%	Not Covered
Surgical Treatment of Morbid Obesity	75%	50% up to $50,000
Primary Doctor Office Visit or Retail Clinic Visit (Includes general or family practice, internists, pediatricians, OB/GYN physicians and mental health providers)	75%	55%

Description of Service	Network	Non-Network
All charges are subject to the Calendar Year Deductible unless otherwise noted.		
Specialist Physician Office Visit	75%	55%
All services other than the Office Visit during the Primary Doctor or Specialist Office Visit	75%	55%
Chiropractic and Osteopathic Manipulation	75%	55%
Durable Medical Equipment	75%	55%
Hearing Aids or Devices and related services - Limited to one hearing instrument for each ear every 36 months	75%	55%
Physical, Speech or Occupational Therapy	75%	55%
Home Health Care Home Infusion Skilled Nursing Facility Hospice Care (including Pediatric Palliative Care)	75%	55%
All Other Covered Expenses	75%	55%

PRESCRIPTION DRUG CARD BENEFIT

Under an HDHP, most prescription drug charges are subject to the Calendar Year Deductible, but IRS guidelines allow such plans to cover certain preventive and maintenance drugs before the deductible. For those drugs the plan Coinsurance is shown below, unless a drug qualifies as a preventive drug that must be provided at no cost to you under the Affordable Care Act. For all other drugs you must pay 100% of the discounted charge for each prescription until you satisfy the Individual Calendar Year Deductible (if you have individual coverage), or until you and all covered family members satisfy the Family Calendar Year Deductible (if you are enrolled for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage). After you satisfy the applicable Calendar Year Deductible, the plan benefit shown below will apply until your out-of-pocket expenses satisfy the Calendar Year Out-of-Pocket Maximum. The Plan will then pay 100% of the cost of your covered prescription drugs for the remainder of the year. Preventive drug lists can be found on the Egyptian Trust website at www.egtrust.org.

The prescription drug program is managed by Prime Therapeutics. You have the option to fill the first two months of a newly prescribed **Brand Name** maintenance medication at any Prime Advantage network retail pharmacy. After the first two fills, **Brand Name** maintenance medications are required to be filled through Home Delivery. You can fill any covered medication that is not a maintenance or specialty medication at any network retail pharmacy. **CVS pharmacies are not in the Prime Advantage network.**

You are required to purchase specialty drugs that are self-administered through the network Specialty Pharmacy. Specialty drugs are very high cost biologic and injectable drugs that are not typically stocked by retail pharmacies. In most cases specialty drugs are limited to a 30 day supply. **If you try to fill a specialty script at retail after your first fill, the pharmacy will notify you that the drug must be ordered from Accredo Specialty Pharmacy.** You can contact Accredo at **1 (833) 721-1619**. Any specialty drug administered in a physician's office, clinical or hospital setting will be covered under the plan's medical benefit.

Prescription Drug Coverage	Participating Pharmacy	Non-Participating Pharmacy (Non-Network)
Generic	75%	55%
Preferred Brand	75%	55%
Non-Preferred Brand	75%	55%
Oral & Injectable Specialty Drugs*	Member pays 3% to a maximum of $400	n/a
* First specialty fill may be at retail (if available), thereafter you MUST use the network Specialty Pharmacy.		

WELLNESS BENEFIT

The Plan covers certain routine health care services and recommended preventive services based on guidelines published by the USPSTF, CDC, and HRS (the Guidelines), as described under Preventive Care Services in the Special Conditions and Payment section of the Plan Document and Summary Plan Description and as outlined on the following page.

Description of Wellness Service	Network	Non-Network
Charges are not subject to the Calendar Year Deductible except as noted. Copayments and Deductibles will apply towards satisfaction of your Calendar Year Out-of-Pocket Maximum.		
Wellness Office Visit for Children (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	55%, after deductible
Wellness Office Visit for Adolescents and Adults (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	55%, after deductible
Childhood Immunizations and Vaccinations per Guidelines	100%	100%
Adult Immunizations and Vaccinations per Guidelines; Includes HPV vaccine	100%	55%, after deductible
Flu vaccine	100%	100% up to $40 maximum
Pneumonia vaccine per Guidelines	100%	100% up to $85 maximum
Zoster (Zostavax) for Shingles per Guidelines	100%	100% up to $200 maximum
Tetanus, Diptheria Toxoids per Guidelines	100%	100% up to $40 maximum
Hepatitis A and B per Guidelines	100%	100% up to $100 maximum
Combined Tetanus, Diptheria and Pertussis (TDAP) per Guidelines	100%	100% up to $55 maximum
Routine Mammogram	100%	100%
Routine Pap Smear	100%	100%
Routine PSA Test	100%	100%
Routine Laboratory, X-ray and Screening Tests recommended by the Guidelines.	100%	55%, after deductible
Routine Screening for Colorectal Cancer using fecal occult blood testing, Cologuard, sigmoidoscopy or colonoscopy (age 45 and over). Frequency as provided by Guidelines.	100%	55%, after deductible
Other recommended preventive services (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	55%, after deductible

Recommended Preventive Services

The following is a **partial list** of services that are covered by the Plan when recommended for individuals of the patient's age, gender or health risk factors, in accordance with Guidelines published by the USPSTF, CDC or HRSA. An up-to-date list of the current Guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/

For Children:

- Well child exams
- Standard routine immunizations recommended by the Guidelines
- Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia
- Gonorrhea preventive medication for eyes in at risk newborns
- Standard metabolic screening panel for inherited enzyme deficiency diseases
- Screening and counseling for obesity
- Evaluation for fluoride treatment and fluoride supplements
- Behavioral assessments
- Screening for autism (at 18 and 24 months)
- Vision screening
- Oral health assessment
- Developmental screening, autism screening and behavioral assessment
- Screening for lead and tuberculosis

For Adolescents and Adults (appropriate age, gender, and/or health risk factors may apply):

- Annual physical exam
- Annual screening mammogram
- Annual pap smears, screening for cervical cancer, HPV testing
- Annual PSA test/screening for prostate cancer
- Evaluation, counseling and genetic testing for BRCA breast cancer gene and/or for chemoprevention for individuals at high risk for breast cancer due to family history or other factors
- Screening during pregnancy for anemia, gestational diabetes, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility
- Screening for abdominal aortic aneurysm (men ages 65-75 with smoking history)
- Screening for gonorrhea, chlamydia, syphilis
- Counseling and equipment to promote and aid with breast feeding
- Folic acid supplements during pregnancy
- Screening for domestic and interpersonal violence
- Osteoporosis screening (women age 60 or older)
- FDA approved contraceptive methods, sterilization procedures and counseling
- Screening for elevated cholesterol and lipids, high blood pressure, diabetes
- Screening and counseling for certain sexually transmitted diseases and HIV
- Screening and counseling for hepatitis B and C
- Screening and counseling for alcohol abuse in a primary care setting
- Screening, counseling and interventions for tobacco use
- Screening and counseling for obesity, diet and nutrition
- Screening for depression in a primary care setting
- Screening for colorectal cancer (over age 45)
- Screening for lung cancer (over age 50 with smoking history)
- Standard routine immunizations recommended by the Guidelines
- Aspirin to prevent cardiovascular disease (women ages 55-79; men ages 45-79)

A detailed listing of women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

In some cases the Guidelines specify how often the Plan must cover a service as a recommended preventive service when provided by a Network provider. In other cases, the Plan may impose reasonable frequency limits or may use reasonable medical management techniques to ensure that care is provided in an appropriate setting.