

### 2026 Surest and Consumer Choice Medical Plan Comparison

| Plan Design                                                            | Surest Plan    |                | Consumer Choice                                                                   |                                                                                   |
|------------------------------------------------------------------------|----------------|----------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
|                                                                        | In-Network     | Out-of-Network | In-Network                                                                        | Out-of-Network                                                                    |
| <b>Deductible</b>                                                      | \$0            |                | Employee Only: \$1,700<br>All Other Coverage Levels: \$3,400                      | Employee Only: \$2,500<br>All Other Coverage Levels: \$5,000                      |
| <b>Coinsurance (Plan Paid)</b>                                         | 100%           |                | After you meet your deductible, you pay 10% for medical and 20% for prescriptions | After you meet your deductible, you pay 30% for medical and 50% for prescriptions |
| <b>OOP Limit Individual - includes medical and prescription copays</b> | \$4,000        | \$8,000        | \$2,500                                                                           | \$5,000                                                                           |
| <b>OOP Limit Family - includes medical and prescription copays</b>     | \$8,000        | \$16,000       | \$5,000                                                                           | \$10,000                                                                          |
| <b>Office Visit</b>                                                    | \$20 to \$75   | \$220          | 10% after the deductible is met                                                   | 30% after the deductible is met                                                   |
| <b>Virtual Care/Telehealth Services</b>                                |                |                |                                                                                   |                                                                                   |
| Virtual Health (Primary and Urgent)                                    | \$0            | Not Covered    | 10% after the deductible is met                                                   | 30% after the deductible is met                                                   |
| Virtual Health (Mental Health & Substance Use)                         | \$20 to \$40   | Not Covered    | 10% after the deductible is met                                                   | 30% after the deductible is met                                                   |
| Virtual Health (Specialty)                                             | \$0 to \$75    | Not Covered    | 10% after the deductible is met                                                   | 30% after the deductible is met                                                   |
| <b>Preventive Care</b>                                                 | \$0            | \$115          | \$0                                                                               | 30% after deductible is met for mammograms, pap smears, and maternity screening   |
| <b>Diagnostic Test (e.g. X-ray, Lab, Ultrasound)</b>                   | \$0            | \$0            | 10% after the deductible is met                                                   | 30% after the deductible is met                                                   |
| <b>Complex Imaging (MRI, CT, etc.)</b>                                 | \$100 to \$600 | Up to \$1,800  | 10% after the deductible is met                                                   | 30% after the deductible is met                                                   |
| <b>Emergency Room</b>                                                  | \$350          | \$350          | 10% after the deductible is met                                                   | 10% after the in-network deductible is met                                        |
| <b>Observation Stay</b>                                                | \$350          | \$350          | 10% after the deductible is met                                                   | 10% after the in-network deductible is met                                        |
| <b>Ambulance</b>                                                       | \$150          | \$150          | 10% after the deductible is met                                                   | 10% after the in-network deductible is met                                        |
| <b>Urgent Care</b>                                                     | \$35           | \$105          | 10% after the deductible is met                                                   | 10% after the in-network deductible is met                                        |

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|                                                                                       | In-Network       | Out-of-Network | In-Network                      | Out-of-Network                  |
| <b>Procedures (Office, Outpatient and Inpatient)</b>                                  | \$15 to \$2,500  | Up to \$7,000  | 10% after the deductible is met | 30% after the deductible is met |
| <b>Procedures (Inpatient and some Outpatient)</b>                                     | \$200 to \$2,500 | Up to \$7,000  | 10% after the deductible is met | 30% after the deductible is met |
| Other Outpatient Hospital Services                                                    | \$75 to \$525    | \$1,575        | 10% after the deductible is met | 30% after the deductible is met |
| Other Inpatient Stay (inc. admission from ER)                                         | \$1,600          | \$4,800        | 10% after the deductible is met | 30% after the deductible is met |
| <b>Mental Health &amp; Substance Use Disorder</b>                                     |                  |                |                                 |                                 |
| In an office setting                                                                  | \$20             | \$115          | 10% after the deductible is met | 30% after the deductible is met |
| Intensive Outpatient Treatment Program                                                | \$40             | \$120          | 10% after the deductible is met | 30% after the deductible is met |
| Partial Hospitalization Program                                                       | \$75             | \$225          | 10% after the deductible is met | 30% after the deductible is met |
| In an outpatient setting                                                              | \$75             | \$225          | 10% after the deductible is met | 30% after the deductible is met |
| In an inpatient setting                                                               | \$1,200          | \$3,600        | 10% after the deductible is met | 30% after the deductible is met |
| <b>Maternity</b>                                                                      |                  |                |                                 |                                 |
| Routine Prenatal and Postnatal Care                                                   | \$0              | \$115          | \$0                             | 30% after the deductible is met |
| Delivery                                                                              | \$350 to \$1,600 | \$4,800        | 10% after the deductible is met | 30% after the deductible is met |
| <b>Home Health Care</b>                                                               | \$35             | \$105          | 10% after the deductible is met | 30% after the deductible is met |
| <b>Rehabilitative Therapies</b>                                                       | \$5 to \$85      | Up to \$220    | 10% after the deductible is met | 30% after the deductible is met |
| Acupuncture                                                                           | Not Covered      | Not Covered    | Not Covered                     | Not Covered                     |
| Chiropractic – 25 visit maximum                                                       | \$20             | Not Covered    | 10% after the deductible is met | Not Covered                     |
| Occupational Therapy (OT)*                                                            | \$10 to \$65     | \$185          | 10% after the deductible is met | 30% after the deductible is met |
| Physical Therapy (PT)*                                                                | \$5 to \$45      | \$135          | 10% after the deductible is met | 30% after the deductible is met |
| Speech Therapy (ST)*                                                                  | \$10 to \$65     | \$185          | 10% after the deductible is met | 30% after the deductible is met |
| * 180 visits per calendar year (OT, PT, ST, and Cardiac and Pulmonary Rehab combined) |                  |                |                                 |                                 |
| <b>Skilled Nursing Facility</b>                                                       | \$1,200          | \$3,600        | 10% after the deductible is met | 30% after the deductible is met |
| <b>Durable Medical Equipment</b>                                                      | \$0 to \$500     | Up to \$1,000  | 10% after the deductible is met | 30% after the deductible is met |
| <b>Hearing Aids Per Ear Every 36 months</b>                                           | \$400 copay      | Not Covered    | 10% after the deductible is met | Not Covered                     |

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|--------------------------|-----------------|----------------|---------------------------------|---------------------------------|
|                          | In-Network      | Out-of-Network | In-Network                      | Out-of-Network                  |
| <b>Hospice</b>           |                 |                |                                 |                                 |
| Home Hospice Visit       | \$35            | \$105          | 10% after the deductible is met | 30% after the deductible is met |
| Inpatient Hospice Care   | \$1,600         | \$4,800        | 10% after the deductible is met | 30% after the deductible is met |
| <b>Advanced Tests</b>    | \$10 to \$800   | Up to \$2,400  | 10% after the deductible is met | 30% after the deductible is met |
| <b>Chemotherapy</b>      | \$10 to \$550   | Up to \$1,650  | 10% after the deductible is met | 30% after the deductible is met |
| <b>Medical Infusions</b> | \$20 to \$2,000 | Up to \$6,000  | 10% after the deductible is met | 30% after the deductible is met |

| Plan Design                                                       | Surest Plan |                | Consumer Choice   |                     |                                                                          |
|-------------------------------------------------------------------|-------------|----------------|-------------------|---------------------|--------------------------------------------------------------------------|
|                                                                   | In-Network  | Out-of-Network | In-Network        |                     | Out-of-Network                                                           |
| <b>Preventive Pharmacy<br/>Up to 90 Days Supply</b>               | \$0         | Not Covered    | \$0               |                     | Not Covered                                                              |
| <b>Retail Pharmacy<br/>Up to 30 Days Supply</b>                   |             |                | Before Deductible | After Deductible    |                                                                          |
| Generic                                                           | \$10        | Not Covered    | 20%               | \$10 Min \$75 Max   | 50% after the deductible is met. Member must file a claim.               |
| Preferred Brand                                                   | \$50        | Not Covered    | 20%               | \$25 Min \$150 Max  |                                                                          |
| Non-Preferred Brand                                               | \$75        | Not Covered    | 20%               | \$40 Min \$250 Max  |                                                                          |
| <b>Retail and Mail Order Pharmacy<br/>Up to 90 Days Supply</b>    |             |                | Before Deductible | After Deductible    |                                                                          |
| Generic                                                           | \$25        | Not Covered    | 20%               | \$20 Min \$150 Max  | Retail only - 50% after the deductible is met. Member must file a claim. |
| Preferred Brand                                                   | \$125       | Not Covered    | 20%               | \$60 Min \$300 Max  |                                                                          |
| Non-Preferred Brand                                               | \$175       | Not Covered    | 20%               | \$100 Min \$500 Max |                                                                          |
| <b>Specialty Pharmacy - Accredo Only<br/>Up to 30 Days Supply</b> |             |                | Before Deductible | After Deductible    |                                                                          |
| Generic                                                           | \$50        | Not Covered    | 20%               | \$10 Min \$75 Max   | Not Covered                                                              |
| Preferred Brand                                                   | \$100       | Not Covered    | 20%               | \$25 Min \$150 Max  |                                                                          |
| Non-Preferred Brand                                               | \$150       | Not Covered    | 20%               | \$40 Min \$250 Max  |                                                                          |
| <b>Specialty Pharmacy - Accredo Only<br/>Up to 90 Days Supply</b> |             |                | Before Deductible | After Deductible    |                                                                          |
| Generic                                                           | \$125       | Not Covered    | 20%               | \$20 Min \$150 Max  | Not Covered                                                              |
| Preferred Brand                                                   | \$250       | Not Covered    | 20%               | \$60 Min \$300 Max  |                                                                          |
| Non-Preferred Brand                                               | \$375       | Not Covered    | 20%               | \$100 Min \$500 Max |                                                                          |