SCHEDULE OF BENEFITS

Creekstone Landscape & Excavating, LLC
Preferred Provider Organization (PPO)
Group Health Plan Medical Benefits

For You and Your Dependents

Medical benefits provide coverage for care In-Network and Out-of-Network. To receive medical benefits, you and your Dependents may have to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance. Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations, and provisions. See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

You may be responsible to pay for Excess Charges from Out-of-Network Providers and Facilities if the services do not qualify as Emergency Services, Air Ambulance Services, or if services were not provided at an In-Network Facility. In some cases, you may be responsible for paying Excess Charges only if the Out-of-Network Provider gave you a written notice and secured your consent to pay the Excess Charges.

Coinsurance

The term Coinsurance is the defined as the percentage of the Allowed Amount that you must pay for Covered Expenses to the Provider and/or Facility. Once you have met any applicable Deductible amount, your percentage will be applied to the Allowed Amount for Covered Expenses to determine your financial responsibility. The Plan's percentage will be applied to the Allowed Amount for Covered Expenses to determine the Benefits provided.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for Covered Expenses. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this Plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule of Benefits has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.

This Plan has an Embedded Deductible. This means family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.

Out of Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the Plan because of any Deductibles, Copayments or Coinsurance. When the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached, all Covered Expenses, except charges for non-compliance penalties and non-covered services, are payable by the Plan at 100% of the Allowed Amount. The Out-of-Pocket Maximum includes Out-of-Pocket Expenses for both Medical and Prescription services.

This Plan has an Embedded Out-of-Pocket Maximum. This means family members meet only their individual Out-of-Pocket Maximum and then their claims will be covered at 100% of the Allowed Amount; if the family Out-of-Pocket Maximum has been met prior to their individual Out-of-Pocket Maximum being met, their claims will be paid at 100% of the Allowed Amount.

The following Out-of-Network Expenses and charges do not contribute to the Out-of-Pocket Maximum and are not payable by the Plan at 100% of the Allowed Amount when the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached.

- Non-Compliance Penalties
- Provider charges in excess of the Allowed Amount

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). Additionally, all other Plan maximums and service-specific maximums (dollar and occurrence) do not cross-accumulate between In- and Out-of-Network unless otherwise noted.

Plan Year

Plan Year means a twelve-month period beginning on each February 1, 2026.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Deductible • Individual • Family	 $5,000 $10,000	 $10,000 $20,000
Out-of-Pocket Maximum • Individual • Family	 $7,000 $14,000	 $14,000 $28,000
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Office Visit	$25 copayment	50% coinsurance after deductible
Specialist Office Visit	$75 copayment	50% coinsurance after deductible
Virtual Care Visit – Primary Care	$25 copayment	50% coinsurance after deductible
Virtual Care Visit – Specialist	$75 copayment	50% coinsurance after deductible
Virtual Care Visit – Doctor on Demand	No charge	Not covered
Preventive Care *Additional cost-share may apply to non-preventive services provided during a preventive visit.*	No charge	Not covered
Allergy Services (Injections, Serum, Testing)	20% coinsurance after deductible	50% coinsurance after deductible
Laboratory Services	$25 copayment	50% coinsurance after deductible
X-rays and Diagnostic Imaging	$25 copayment	50% coinsurance after deductible
Advanced Imaging (MRI, CT & PET scans, etc.) *Pre-certification is required for certain services.*	20% coinsurance after deductible	50% coinsurance after deductible
EMERGENCY & URGENT CARE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Emergency Room Facility Fee	$300 copayment after deductible	See In-Network Benefit
Emergency Room Physician Fee	20% coinsurance after deductible	See In-Network Benefit
Urgent Care Center	$85 copayment	50% coinsurance after deductible
Ambulance/Emergency Transport (Air & Ground) *Pre-certification is required for non-emergency transportation.*	20% coinsurance after deductible	See In-Network Benefit
OUTPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Hospital Surgery Facility Services *Pre-certification is required for certain services.*	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Physician/Surgeon Services	20% coinsurance after deductible	50% coinsurance after deductible

Outpatient Rehabilitation Services (Physical, Occupational & Speech Therapy) *Pre-certification is required for certain services over 5 visits. Physical, Occupational, and Speech Therapy: 20 visits each.*	$75 copayment	50% coinsurance after deductible
Outpatient Habilitation Services (Physical, Occupational & Speech Therapy) *Pre-certification is required for certain services over 5 visits. Physical, Occupational, and Speech Therapy: 20 visits each.*	$75 copayment	50% coinsurance after deductible
Outpatient Anesthesia Services	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Hospice Services	20% coinsurance after deductible	50% coinsurance after deductible
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Inpatient Hospital Facility Services *Pre-certification is required.*	$300 copayment after deductible	50% coinsurance after deductible
Inpatient Physician/Surgeon Services	20% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility *Pre-certification is required. Up to 60 days per plan year.*	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Rehabilitation Services (Physical, Occupational & Speech Therapy) *Up to 40 days per plan year, combined, for inpatient therapies.*	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Anesthesia Services	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospice Services *Pre-certification is required for certain services.*	20% coinsurance after deductible	50% coinsurance after deductible
MATERNITY & NEWBORN CARE	**PARTICIPATING**	**NONPARTICIPATING**
Prenatal & Postnatal Care *Includes the routine sequence of prenatal care office visits as recommended by the American College of Obstetricians and Gynecologists (ACOG).*	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospital & Birthing Center Facility Fee *Preauthorization required for a hospital stay that will exceed 48 hours following a vaginal birth or 96 hours following a cesarean section.*	$300 copayment after deductible	50% coinsurance after deductible
Newborn Care	20% coinsurance after deductible	50% coinsurance after deductible
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**PARTICIPATING**	**NONPARTICIPATING**
Acupuncture Services *Up to 20 visits per plan year.*	$75 copayment	50% coinsurance after deductible
Blood and Administration	20% coinsurance after deductible	50% coinsurance after deductible
Chemotherapy *Pre-certification is required.*	20% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care *Up to 20 visits per plan year.*	$75 copayment	50% coinsurance after deductible
Cochlear Implants *Pre-certification is required.*	20% coinsurance after deductible	50% coinsurance after deductible
Diabetic Equipment *Pre-certification is required for certain services.*	20% coinsurance after deductible	50% coinsurance after deductible
Diabetic Supplies *Preauthorization may be required for certain services. Limited to a 90-day supply.*	20% coinsurance after deductible	50% coinsurance after deductible

Durable Medical Equipment, Prosthetics & Orthotics *Pre-certification is required.*	20% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids	Not covered	Not covered
Home Health Care Services *Pre-certification is required. Up to 100 visits per plan year.*	20% coinsurance after deductible	50% coinsurance after deductible
Infertility Services	Not covered	Not covered
Intravenous Therapy *Pre-certification is required.*	20% coinsurance after deductible	50% coinsurance after deductible
Miscellaneous Medical Supplies	20% coinsurance after deductible	50% coinsurance after deductible
Nutritional Counseling	20% coinsurance after deductible	50% coinsurance after deductible
Pre-Admission Testing	20% coinsurance after deductible	50% coinsurance after deductible
Pulmonary and Respiratory Therapy	20% coinsurance after deductible	50% coinsurance after deductible
Radiation Therapy	20% coinsurance after deductible	50% coinsurance after deductible
Sleep Study	20% coinsurance after deductible	50% coinsurance after deductible
TMJ (Temporomandibular Joint) Services	Not covered	Not covered
Transplant *Pre-certification is required.*	20% coinsurance after deductible	50% coinsurance after deductible
All Other Covered Services	Benefits based on place of service and subject to applicable Copay, Coinsurance and/or, Deductible	Benefits based on place of service and subject to applicable Copay, Coinsurance and/or, Deductible
MENTAL HEALTH, CHEMICAL DEPENDENCY & SUBSTANCE ABUSE SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Office and Visits	$25 copayment	50% coinsurance after deductible
Virtual Care Visits – Physician Visit	$25 copayment	50% coinsurance after deductible
Virtual Care Visits – Doctor on Demand *Telemedicine must be $0.00 after deductible for qualified HDHPs.*	No charge	Not covered
Inpatient Care *Preauthorization required except in the case of an emergency.*	$300 copayment after deductible	50% coinsurance after deductible
Intensive Outpatient Treatment	20% coinsurance after deductible	50% coinsurance after deductible
Residential Treatment Center *Preauthorization may be required for certain services.*	$300 copayment after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS	**PARTICIPATING**	**NONPARTICIPATING**
Retail Pharmacy (31-Day Supply) *Preauthorization and/or step therapy may be required.*		
Tier 1 - Generic Drugs	$20 copayment	Not covered
Tier 2 - Preferred Brand Drugs	$60 copayment	Not covered
Tier 3 - Non-Preferred Brand Drugs	$85 copayment	Not covered
Tier 4 - Specialty Drug (31-Day supply)	20% coinsurance after deductible	Not covered

Mail Order Pharmacy (90-Day Supply) *Preauthorization and/or step therapy may be required.*		
Tier 1 - Generic Drugs	$50 copayment	Not covered
Tier 2 – Preferred Brand Drug	$150 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	$212.50 copayment	Not covered
Tier 4 - Specialty Drug (31-Day Supply Only)	Not covered	Not covered
DENTAL & VISION CARE *(Adult & Child)*	**PARTICIPATING**	**NONPARTICIPATING**
Adult Dental Services	Not covered	Not covered
Adult Vision Exams	Not covered	Not covered
Lenses, Frames, and Contact Lenses	Not covered	Not covered

NOTE: All deductible/copay/coinsurance amounts and plan payments are based on allowed amounts only and not on the provider's billed or other charges. You may be responsible to pay for charges in excess of Allowed Amounts for Covered Expenses obtained from Out-of-Network Providers and Facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Plan Document and Summary Plan Description for more information.