Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: Beginning on or after 09/01/2026 **Coverage for:** Individual + Family **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 844-573-3322 or visit employeewellnesshub.app. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 844-573-3322 to request a copy.

Important Questions

Important Questions	Answers	Why This Matters
What is the overall deductible?	Network: $1,250 individual / $2,500 family. Out-of-network: $2,500 individual / $5,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services that have a copayment without a deductible (primary care, specialist and urgent care visits, independent labs, stand-alone x-rays, chiropractic care, outpatient mental health visits, nutritional counseling, telemedicine and generic drugs) are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart below for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Network: $9,200 individual / $18,400 family. Out-of-network: $18,400 individual / $36,800 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, charges above the allowed amount, health care this plan doesn't cover, penalties for not getting preauthorization, and prescription drug penalties or costs paid with a discount or copay card.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Network and out-of-network deductibles and out-of-pocket limits are separate and do not cross-accumulate, except as required by the No Surprises Act.
Will you pay less if you use a network provider?	Yes. See employeewellnesshub.app or call 844-573-3322 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

What You Will Pay for Common Medical Events

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit; deductible does not apply	$50 copay + 40% coinsurance	Virtual primary and urgent care through Our Live Doc (940-548-3362) and behavioral health telemedicine (866-890-3741) are $0 copay, network only; limits may apply per episode.
	Specialist visit	$75 copay/visit; deductible does not apply	$75 copay + 40% coinsurance	No referral needed.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preventive care/screening/immunization	No charge; deductible does not apply	40% coinsurance	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. See the Preventive Care Guide in your plan document.
If you have a test	Diagnostic test (x-ray, blood work)	Independent labs: $35 copay. X-rays (stand-alone radiology): $75 copay. Deductible does not apply. Outpatient labs: $100 copay.	Same copays + 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$500 copay/test	$500 copay + 40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced by 50% of allowed charges or the claim may be denied.
If you need drugs to treat your illness or condition. More information is available from VerusRx at 800-838-0007 or verus-rx.com	Generic drugs	$0 copay (30-day retail or 90-day mail order); deductible does not apply	40% coinsurance	30-day supply at retail, then mail order is required. Preventive drugs: $0 copay. Prior authorization, step therapy and quantity limits may apply. See the formulary.
	Preferred brand drugs	Not covered	Not covered	A Patient Assistance Program (PAP) is available. GLP-1 medication is not covered.
	Non-preferred brand drugs	Not covered	Not covered	A Patient Assistance Program (PAP) is available.
	Specialty drugs	Not covered	Not covered	A Patient Assistance Program (PAP) is available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$2,500 copay/surgery	$2,500 copay/surgery + 40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced by 50% of allowed charges or the claim may be denied.
	Physician/surgeon fees	$250 copay/service	$250 copay/service + 40% coinsurance	Anesthesia, pathology and other incidental services: $250 copay/service.
If you need immediate medical attention	Emergency room care	$1,000 copay/visit	$1,000 copay/visit + 40% coinsurance	Out-of-network Emergency claims processed in compliance with the No Surprises Act. Observation room: $1,000 copay.
	Emergency medical transportation	Land: $500 copay. Air: $1,000 copay.	Land: $500 copay. Air: $1,000 copay.	2 per year, land and air combined. Out-of-network ambulance claims are processed under the No Surprises Act.
	Urgent care	$90 copay/visit; deductible does not apply	$90 copay + 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,500 copay/admission	$2,500 copay/admission + 40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced by 50% of allowed charges or the claim may be denied.
	Physician/surgeon fees	Surgeon: $2,500 copay/surgery. Other services: $250 copay/service.	Same copays + 40% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copay/visit; deductible does not apply	$75 copay + 40% coinsurance	None
	Inpatient services	$2,500 copay/admission	$2,500 copay/admission + 40% coinsurance	Preauthorization is required. Partial hospitalization/intensive outpatient: $125 copay/day. Residential treatment: $125 copay/day, 21 days/year.
If you are pregnant	Office visits	No charge (after deductible)	40% coinsurance	Routine prenatal and postnatal care (office visits, lab work, radiology) is covered at 100% after the deductible. Genetic testing is excluded. Other services are covered as described elsewhere in this chart.
	Childbirth/delivery professional services	$500 copay	$500 copay + 40% coinsurance	None

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	$2,500 copay/admission	$2,500 copay/admission + 40% coinsurance	Preauthorization is required. Inpatient limits apply.
If you need help recovering or have other special health needs	Home health care	$50 copay/visit	$50 copay/visit + 40% coinsurance	10 visits/year. Preauthorization is required.
	Rehabilitation services	$150 copay/visit	$150 copay/visit + 40% coinsurance	16 visits/year, combined physical, occupational, speech, cardiac and respiratory therapy.
	Habilitation services	$150 copay/visit	$150 copay/visit + 40% coinsurance	Included in the 16-visit combined limit above. ABA and TMS (preauthorization required) have a separate 16-visit/year combined limit.
	Skilled nursing care	$125 copay/day	$125 copay/day + 40% coinsurance	21 days/year.
	Durable medical equipment	$50 copay/item	$50 copay/item + 40% coinsurance	5 items/year. Preauthorization is required for items over $750.
	Hospice services	$0 copay	40% coinsurance	Limited to 30 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision services are excluded.
	Children's glasses	Not covered	Not covered	Eyeglasses and contact lenses are excluded.
	Children's dental check-up	Not covered	Not covered	Routine dental care is excluded.

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture and massage therapy
- Brand-name drugs, GLP-1 medication and specialty drugs (Patient Assistance Program available)
- Cosmetic surgery
- Dental care (adult and child)
- Eyeglasses, contact lenses and routine vision exams
- Gender-affirming services
- Hearing aids (except as required by law)
- Infertility treatment (diagnostic testing is covered)
- Long-term care and custodial care
- Non-emergency care when traveling outside the U.S.
- Over-the-counter drugs and supplies
- Private-duty nursing
- Routine foot care
- Weight loss programs and obesity treatment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- ABA and TMS therapy ($150 copay/visit; preauthorization required; 16 visits/year)
- Allergy shots ($25 copay; 12 visits/year) and allergy visits/testing ($50 copay; 1 visit/year)
- Chiropractic care ($60 copay; 12 visits/year)
- Dialysis ($400 copay), outpatient chemotherapy/radiotherapy ($350 copay/visit) and infusion/injection ($250 copay/visit)
- Nutritional counseling ($0 copay; 1 visit/year)
- Organ transplant ($2,500 copay/admission)
- Prosthetics ($500 copay/item; preauthorization required)
- Telemedicine through Our Live Doc ($0 copay; network only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ameribenefit Human Resource Department, 844-573-3322; U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Marpai Member Services, PO Box 211291, Eagan, MN 55121, 844-573-3322; U.S. Department of Labor, EBSA, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; U.S. Department of Health and Human Services, 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 844-573-3322.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-573-3322.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-573-3322.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-573-3322.
- Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 844-573-3322 uff.
- Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 844-573-3322.
- Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 844-573-3322.
- Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 844-573-3322.

To see examples of how this plan might cover costs for a sample medical situation, see the next section. The valid OMB control number for this information collection is 0938-1146.

About these Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

	Peg is Having a Baby	Managing Joe's Type 2 Diabetes	Mia's Simple Fracture
Situation	9 months of in-network pre-natal care and a hospital delivery	A year of routine in-network care of a well-controlled condition	In-network emergency room visit and follow-up care
Plan cost sharing used	Overall deductible $1,250; specialist $75 copay; hospital (facility) $2,500 copay; other $250 copay	Overall deductible $1,250; specialist $75 copay; hospital (facility) $2,500 copay; other $0 copay (generic drugs)	Overall deductible $1,250; specialist $75 copay; hospital (facility) $1,000 copay (emergency room); other $50 copay (equipment); therapy $150 copay
This EXAMPLE event includes services like	Specialist office visits (prenatal care); childbirth/delivery professional services; childbirth/delivery facility services; diagnostic tests (ultrasounds and blood work); specialist visit (anesthesia)	Primary care physician office visits (including disease education); diagnostic tests (blood work); prescription drugs; durable medical equipment (glucose meter)	Emergency room care (including medical supplies); diagnostic test (x-ray); durable medical equipment (crutches); rehabilitation services (physical therapy)
Total Example Cost	**$12,700**	**$5,600**	**$2,800**
Deductibles	$1,300	$0	$1,300
Copayments	$3,300	$600	$1,100
Coinsurance	$0	$0	$10
Limits or exclusions (what isn't covered)	$700	$20	$0
The total the patient would pay is	**$5,300**	**$620**	**$2,410**

The plan would be responsible for the other costs of these EXAMPLE covered services.