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

Coverage Period: 12/01/2026-12/31/2026

Health Plan: AmerusSummit Health Plans : EPO 5000

Coverage for: Individual + Family | Plan Type: EPO

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, contact InovaCare, the Plan Administrator, at [Member Services Phone]. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000 Individual / $10,000 Family for In-Network. Out-of-network care is not covered except emergencies.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visit copays (primary care, specialist, urgent care), telehealth and prescription 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.
What is the out-of-pocket limit for this plan?	$9,000 Individual / $18,000 Family for In-Network.	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, penalties for failure to obtain pre-certification, prescription drug costs above the $500 per-prescription maximum, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. This plan uses the Cigna network and covers in-network care only, except emergencies. Search providers at hcpdirectory.cigna.com or call InovaCare at [Member Services Phone] 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.

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* For more information about limitations and exceptions, see the plan document.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copay/Visit, Deductible Does Not Apply	Not Covered	Telehealth through the ConnectedCare app (powered by OpynHealth): $0 copay, unlimited visits. Telehealth is not covered out-of-network.
	Specialist visit	$60 Copay/Visit, Deductible Does Not Apply	Not Covered	Covered starting on the 31st day of coverage; primary care and wellness visits are covered from the first day. No referral needed. Chiropractic care: $75 copay/visit; the plan pays up to $150 per visit, 15 visits/calendar year. Podiatry is not covered.
	Preventive care/screening/immunization	$0 Copay, Deductible Does Not Apply	Not Covered	Covered from the first day of coverage. 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.
If you have a test	Diagnostic test (x-ray, blood work)	30% After Deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% After Deductible	Not Covered	Pre-certification required.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available from ConnectedCare Rx (Unified Labor Rx)	Generic drugs	$0 Copay (retail and mail order)	Not Covered	Managed by ConnectedCare Rx (powered by Unified Labor Rx), 844-654-2111. Network pharmacies only. Retail: 30-day supply. Mail order: 90-day supply. Per formulary. Preventive Rx: $0 copay.
	Preferred brand drugs	Tier 1: $35 Copay. Tier 2: 25% Coinsurance	Not Covered	The plan pays no more than $500 per prescription for any covered drug. Medications that cost more than $500 are sourced through the ConnectedCare Rx Pharmacy Exchange (Patient Assistance Programs and direct sourcing); members must enroll when directed.
	Non-preferred brand drugs	Tier 3: 45% Coinsurance	Not Covered	The plan pays no more than $500 per prescription.
	Specialty drugs	Not Covered	Not Covered	Specialty drugs are available only through the Unified Labor Rx importation program.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% After Deductible	Not Covered	Pre-certification required. Elective surgery is not covered for the first 3 months of coverage.
	Physician/surgeon fees	30% After Deductible	Not Covered	Surgeon's charges are part of surgery services, along with anesthesia and other services associated with outpatient surgery.
If you need immediate medical attention	Emergency room care	$500 Copay/Visit plus Deductible and 30% Coinsurance	$500 Copay/Visit plus Deductible and 30% Coinsurance (true emergency)	Any provider for true medical emergencies, with no out-of-network penalty. Pre-certification required within 48 hours if admitted.
	Emergency medical transportation	Ground: 30% After Deductible. Air: Not Covered	Ground: 30% After Deductible. Air: Not Covered	Air ambulance, including emergency air ambulance, is not covered. Non-emergency ambulance transport is not covered. Out-of-network ground ambulance claims are processed in compliance with the No Surprises Act (NSA).
	Urgent care	$100 Copay/Visit, Deductible Does Not Apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% After Deductible	Not Covered	Includes partial hospitalization. Pre-certification required.
	Physician/surgeon fees	30% After Deductible	Not Covered	Associated services include anesthesia, pathology and physician services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $60 Copay/Visit, Deductible Does Not Apply. Other Outpatient Services: 30% After Deductible	Not Covered	Same cost sharing as a specialist office visit. Behavioral health telehealth through the ConnectedCare app (powered by OpynHealth): $0 copay.
	Inpatient services	30% After Deductible	Not Covered	Same cost sharing as an inpatient hospital stay. Pre-certification required.
If you are pregnant	Office visits	Preventive Prenatal Care: $0 Copay. Other Visits: $75 Copay/Visit, Deductible Does Not Apply	Not Covered	Pregnancy and childbirth expenses of Dependent Children, including adult Dependent Children, are not covered except preventive prenatal care. Newborns of Dependent Children are not eligible.
	Childbirth/delivery professional services	30% After Deductible	Not Covered	Not covered for Dependent Children.
	Childbirth/delivery facility services	30% After Deductible	Not Covered	Pre-certification required if the stay exceeds 48 hours (vaginal) or 96 hours (C-section). Not covered for Dependent Children.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% After Deductible	Not Covered	60 visits/benefit year. Pre-certification required.
	Rehabilitation services	Outpatient Therapy: 30% After Deductible. Inpatient Rehab Facility: 30% After Deductible	Not Covered	Outpatient: 35 visits/benefit year combined for physical, occupational, speech, ABA and respiratory therapy. Inpatient: 30 days/calendar year. Pre-certification required.
	Habilitation services	Outpatient Therapy: 30% After Deductible	Not Covered	Combined with the rehabilitation services limits above.
	Skilled nursing care	30% After Deductible	Not Covered	30 days/calendar year. Pre-certification required.
	Durable medical equipment	30% After Deductible	Not Covered	Limited to 12-month rental or purchase price, whichever is less. Pre-certification required for DME over $500.
	Hospice services	30% After Deductible	Not Covered	Residential/facility hospice: 30 days/benefit year. Pre-certification required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Except when qualified under preventive care.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Failure to obtain required pre-certification may result in a 50% reduction of allowed charges or denial of the claim. Pre-certification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME over $500, chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Emergencies are covered but require authorization within 48 hours or the next business day.

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
- Air ambulance (including emergency air ambulance)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children's dental check-up)
- Specialist office visits during the first 30 days of coverage
- Elective surgery during the first 3 months of coverage
- Glasses (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency ambulance transport
- Non-emergency care when traveling outside of U.S.
- Out-of-network care (except emergencies)
- Podiatry and routine foot care
- Pregnancy and childbirth of Dependent Children (except preventive prenatal care)
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children's eye exam)
- Specialty drugs (except through the Unified Labor Rx importation program)
- Weight loss programs

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

- Chiropractic care (15 visits/calendar year; plan pays up to $150/visit)
- Dialysis (network only)
- Organ transplant (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: the Department of Labor's Employee Benefits Security Administration at 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.

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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 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 InovaCare at [Member Services Phone] or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-855-699-5433.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-699-5433.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-699-5433.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-699-5433.

——————————— To see examples of how this plan might cover costs for a sample medical situation, see the next page. ———————————

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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

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$5,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	**$5,000**
Copayments	**$120**
Coinsurance	**$2,220**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$7,400**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	**$800**
Copayments	**$580**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,400**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**30%**
ER copayment	**$500**

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	**$2,500**
Copayments	**$620**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$3,120**

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

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