Summary of Benefits & Coverage

Health Shield

by AmeriBenefit Plan

MM Plan Comparison

Rates Effective As of November 1, 2026
Coverage Period: 9/01/26 - 12/31/2026

MM
MAJOR MEDICAL PLAN

CIGNA
NETWORK

INN & OON
BENEFITS

PLAN AT A GLANCE	INN	OON
Individual Deductible	$2,500-$8,100	$5,000-$16,200
Family Deductible	$5,000-$16,200	$10,000-$32,400
Coinsurance	20%	30%
Individual Out-of-Pocket Max	$10,600	$20,300
Family Out-of-Pocket Max	$21,200	$40,600
Annual Maximum Benefit	Unlimited	Unlimited

This document is a summary for general information purposes only.
It is not a substitute for the official plan document or summary plan description, and does not constitute a policy of insurance. Please refer to the full plan document for complete terms, limitations, and benefit details.

COVERED SERVICES

SERVICE	$2,500 MM		$5,300 MM		$8,100 MM	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Office & Outpatient Physician Office Visits (PCP & Specialist)						
Primary Care Physician	$50 Copay	30% Coinsurance After Deductible	$50 Copay	30% Coinsurance After Deductible	$50 Copay	30% Coinsurance After Deductible
Specialist Office Visit *No Referral Needed*	$60 Copay	30% Coinsurance After Deductible	$60 Copay	30% Coinsurance After Deductible	$60 Copay	30% Coinsurance After Deductible
Chiropractic Care *18 Visits/Benefit Year Maximum*	$50 Copay	30% Coinsurance After Deductible	$50 Copay	30% Coinsurance After Deductible	$50 Copay	30% Coinsurance After Deductible
Urgent Care Office Visit	$75 Copay	30% Coinsurance After Deductible	$75 Copay	30% Coinsurance After Deductible	$75 Copay	30% Coinsurance After Deductible
Surgery Performed in Office	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Therapies (Rehabilitation/Habilitation) *20 Visits/Benefit Year maximum combined: physical and occupational, speech, and respiratory*	$100 Copay	30% Coinsurance After Deductible	$100 Copay	30% Coinsurance After Deductible	$100 Copay	30% Coinsurance After Deductible
Therapies *20 Visits/Benefit Year Combined - ABA & TMS. Pre-certification Required.*	$100 Copay	30% Coinsurance After Deductible	$100 Copay	30% Coinsurance After Deductible	$100 Copay	30% Coinsurance After Deductible
Telemedicine - Our Live Doc ONLY *Virtual Primary Care & Virtual Urgent Care: 940-LIVEDOC (940-548-3362) Behavioral Health: 866-890-3741 (Limits may apply per episode with $0 Copay)*	$0 Copay	Not Covered	$0 Copay	Not Covered	$0 Copay	Not Covered
Independent Labs	$25 Copay After Deductible	30% Coinsurance After Deductible	$25 Copay After Deductible	30% Coinsurance After Deductible	$25 Copay After Deductible	30% Coinsurance After Deductible
X-Rays	$100 Copay After Deductible	30% Coinsurance After Deductible	$100 Copay After Deductible	30% Coinsurance After Deductible	$100 Copay After Deductible	30% Coinsurance After Deductible
Diagnostic Testing/Advanced Imaging *Pre-certification Required.*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Mental Health & Substance Abuse						
Outpatient Office Visit	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Inpatient	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible

COVERED SERVICES

SERVICE	$2,500 MM		$5,300 MM		$8,100 MM	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Mental Health / Substance Use Disorder – Partial Hospitalization (PHP)/ Intensive Outpatient Program (IOP)	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Mental Health / Substance Use Disorder – Residential Treatment *30 Days/Benefit Plan Year*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Emergency Services						
Emergency Room Care *Any provider for true medical emergencies.*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Ambulance **Land & Air** *Network applies as applicable per the No Surprises Act*	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Inpatient Hospital Services Pre-certification Required						
Inpatient Hospital Care Facility	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Inpatient Surgical Services	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Inpatient Skilled Nursing Facility *30 Days/Benefit Plan Year*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Inpatient Rehabilitation Facility *30 Days/Benefit Plan Year*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Hospice *30 Days/Lifetime*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Organ Transplant	20% Coinsurance After Deductible	Not Covered	20% Coinsurance After Deductible	Not Covered	20% Coinsurance After Deductible	Not Covered
Outpatient Services Pre-certification Required						
Outpatient Surgical Facility Services	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Outpatient Chemotherapy & Radiotherapy *30 Days/Benefit Plan Year*	20% Coinsurance After Deductible	Not Covered	20% Coinsurance After Deductible	Not Covered	20% Coinsurance After Deductible	Not Covered

COVERED SERVICES

SERVICE	$2,500 MM		$5,300 MM		$8,100 MM	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Infusion/Injection	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Dialysis *Limited to acute temporary dialysis.*	20% Coinsurance After Deductible	Not Covered	20% Coinsurance After Deductible	Not Covered	20% Coinsurance After Deductible	Not Covered
Outpatient Labs *No pre-certification required.*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Associated/Incidental Inpatient & Outpatient Services *Anesthesia, pathology, physician services and other incurred services*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Preventive & Maternity Services						
Preventive Care *Including but not limited to: Annual wellness exams, labs, immunizations. See Preventive Care Guide*	$0 Copay $0 Deductible	30% Coinsurance After Deductible	$0 Copay $0 Deductible	30% Coinsurance After Deductible	$0 Copay $0 Deductible	30% Coinsurance After Deductible
Routine Prenatal/Postnatal Care *Prenatal: office visits, preventive screenings and labs. Postnatal: postpartum visit, depression screening, lactation support and breast pump*	$0 Copay	30% Coinsurance After Deductible	$0 Copay	30% Coinsurance After Deductible	$0 Copay	30% Coinsurance After Deductible
Delivery *Professional services for delivery*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Other Covered Services						
Durable Medical Equipment (DME) *Limited to 12-month rental or purchase price, whichever is less. Pre-certification Required.*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Home Health Care Visits *30 Visits/Benefit Plan Year. Pre-certification Required*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Nutritional Counseling	$0 Copay	30% Coinsurance After Deductible	$0 Copay	30% Coinsurance After Deductible	$0 Copay	30% Coinsurance After Deductible
Prosthetics *1 Item/Benefit Plan Year. Pre-certification Required.*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
Allergy Testing / Injections *1 Visit/Benefit Plan Year. 12 Injections/Benefit Plan Year.*	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible
All Other Covered Services	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible	20% Coinsurance After Deductible	30% Coinsurance After Deductible

PRESCRIPTION DRUGS

Managed by Verus - 1-800-838-0007 - verus-rx.com

HERE

MM FORMULARY

RETAIL PHARMACY *30 Day Supply at Retail, then Mail Order Required - See Formulary*

	INN	OON
Preventive	$0 Copay	30% Coinsurance After Deductible
Generic Drugs *30-day supply at retail for urgent care drugs. 30-day supply maintenance medication at retail.*	$10 Copay	30% Coinsurance After Deductible
Preferred Brand Name *30 day-supply at retail for urgent care drugs. 30-day supply maintenance medication at retail.*	$90 Copay	30% Coinsurance After Deductible
Non-Preferred Brand Name *30 day-supply at retail for urgent care drugs. 30-day supply maintenance medication at retail.*	$110 Copay	30% Coinsurance After Deductible
GLP-1 Medication *See GLP-1 Receptor Agonist Coverage Rider*	Brand Name: $550 Copay	30% Coinsurance After Deductible
Specialty Drugs	PAP Available	PAP Available

MAIL ORDER/RETAIL PHARMACY *90 Day Supply - See Formulary*

	INN	OON
Preventive	$0 Copay	30% Coinsurance After Deductible
Generic Drugs *90 Day Supply*	$20 Copay	30% Coinsurance After Deductible
Preferred Brand Name *90 Day Supply*	$180 Copay	30% Coinsurance After Deductible
Non-Preferred Brand Name *90 Day Supply*	$220 Copay	30% Coinsurance After Deductible
GLP-1 Medication *See GLP-1 Receptor Agonist Coverage Rider*	Brand Name: $1,650 Copay	30% Coinsurance After Deductible
Specialty Drugs	PAP Available	PAP Available

CIGNA PROVIDER SEARCH:

1.Visit: https://www.cigna.com/
2.Select Provider Directory
3.Select Employer or School
4.Enter your zip code. Choose Doctor by Type, Doctor by Name, or Health Facilities. Enter search parameters or choose from the dropdown menu and click Search.
5.Select Continue as Guest
6.Select Continue
7.Select PPO, Choice Fund PPO
8.Choose from the list of results.

GLP-1 RECEPTOR AGONIST COVERAGE RIDER

The Plan covers GLP-1 receptor agonist medications — including but not limited to semaglutide, tirzepatide, and liraglutide, and other formulations approved by the Plan's Pharmacy & Therapeutics guidelines — when prescribed by a licensed provider for an indication supported by the Plan's formulary criteria and/or medical necessity documentation.

MEMBER COST

Members are responsible for the following copayment amounts per fill, up to the supply limit stated below, when obtained through an in-network pharmacy:

Product Type	Member Copay (Per Fill)
Brand-Name GLP-1 Medication *FDA-approved, manufactured product*	**$550**
Compounded GLP-1 Medication *Elected by Member as an alternative to the brand-name product*	**$200**

Supply limit: up to a [30 / 90]-day supply per fill. Copays listed above apply to in-network pharmacy fills only; out-of-network fills are subject to the Plan's standard out-of-network prescription drug provisions. These copay amounts apply regardless of the Plan's general formulary tier structure and supersede any conflicting standard prescription drug copay schedule with respect to GLP-1 receptor agonist products specifically.

CONDITIONS OF COVERAGE FOR COMPOUNDED GLP-1 ALTERNATIVES

Compounded GLP-1 Coverage ($200 Tier) — Conditions
To qualify for the $200 tier, a compounded GLP-1 medication must meet all of the following:

1. **Pharmacy source.** The medication must be dispensed by a state-licensed 503A compounding pharmacy or 503B outsourcing facility that is in good standing.
2. **Regulatory status.** Coverage depends on current FDA guidance and the drug shortage status of the active ingredient(s) used. If compounding that ingredient is no longer legally permitted, the Plan may modify, limit, or end this coverage tier.
3. **Member acknowledgment.** The Member must sign a Plan-approved form confirming they understand the compounded product is not FDA-approved and has not been evaluated by the FDA for safety or effectiveness.
4. **Prior authorization.** Prior authorization may be required to confirm the treatment is clinically appropriate and to document that the Member is choosing the compounded alternative instead of the brand-name product.
5. **Matching indication.** The compounded product must be prescribed for the same indication that would otherwise qualify the brand-name GLP-1 product for coverage under this Rider.

This is just a brief overview of this rider, please see your full plan document for all details.

OTHER COVERED SERVICES

- Cancer Screenings
- Annual Pap Smear/Mammogram
- Colonoscopies
- Diabetic Supply
- Other Preventive Screenings
- Well Baby Care

SERVICES NOT COVERED

- Acupuncture
- Biofeedback
- Children's Glasses
- Children's Eye Exam
- Children's Dental Check-up

PRE-AUTHORIZATION REQUIRED

Pre-certification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME over $750, chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Failure to obtain pre-certification may be a 50% reduction of allowed charges or denial of claim.If you are admitted as an inpatient following Emergency Services, please notify Marpai within 48 hours of admission or by the next business day so that Marpai can coordinate your care.

Notes

- Failure to obtain authorization will result in penalties. The penalty may be a 50% reduction of allowed charges or denial of claim. This penalty does not apply to Emergency Services.
- Elective Surgery/Procedures/Injections will not be covered for the first 90 days of coverage. This 90-day limitation does not apply to preventive services required under the Affordable Care Act (see the Preventive Care Guide), to Emergency Services, or to any service for which applying it would violate applicable law.
- If you have an emergency medical condition, you may go to the nearest emergency room, whether in or out of network. Emergency services are covered at the in-network level.
- Emergency Services never require pre-certification or prior authorization. If you are admitted as an inpatient following Emergency Services, please notify Marpai within 48 hours of admission or by the next business day so that Marpai can coordinate your care. Failure to give this notice will not reduce benefits, result in a penalty, or cause a denial.
- Deductibles and Out-of-pocket Limits for In-network and Out-of-network services are separate and do not cross-accumulate, except as required by the No Surprises Act.
- Deductible shown by level elected. All other benefits are the same for every level.

Copays still apply after your deductible is met.

KEY DEFINITIONS

- **Deductible:** The amount you pay each benefit year for covered services before the plan begins to pay.
- **Out-of-Pocket Maximum:** The most you'll be required to pay for covered services in a benefit year.
- **Copay:** Your fixed payment at the time of service.
- **In-Network Provider:** Providers within the network shown on your ID card. Always confirm status before scheduling care.

MONTHLY PREMIUMS BY AGE

		$2,500 MM	$5,300 MM	$8,100 MM
Ages 18-29	Employee	$689.00	$614.00	$514.00
	Employee + Spouse	$1,219.00	$1,089.00	$909.00
	Employee + Child(ren)	$1,189.00	$984.00	$834.00
	Family	$1,679.00	$1,479.00	$1,199.00
Ages 30-44	Employee	$719.00	$634.00	$534.00
	Employee + Spouse	$1,269.00	$1,119.00	$939.00
	Employee + Child(ren)	$1,249.00	$1,024.00	$864.00
	Family	$1,749.00	$1,539.00	$1,249.00
Ages 45-54	Employee	$759.00	$654.00	$564.00
	Employee + Spouse	$1,319.00	$1,179.00	$989.00
	Employee + Child(ren)	$1,279.00	$1,064.00	$884.00
	Family	$1,819.00	$1,599.00	$1,299.00
Ages 55-64	Employee	$839.00	$684.00	$604.00
	Employee + Spouse	$1,489.00	$1,269.00	$1,049.00
	Employee + Child(ren)	$1,359.00	$1,134.00	$964.00
	Family	$2,099.00	$1,729.00	$1,399.00