Summary of Benefits & Coverage

Health Shield

by AmeriBenefit Plan

PPO Plan Comparison

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

PPO
COPAY PPO PLAN

CIGNA
NETWORK

INN & OON
BENEFITS

PLAN AT A GLANCE	INN	OON
Individual Deductible	$1,250 - $3,500	$2,500 - $7,000
Family Deductible	$2,500 - $7,000	$5,000 - $14,000
Coinsurance	80/20	60/40
Individual Out-of-Pocket Max	$9,200	$18,400
Family Out-of-Pocket Max	$18,400	$36,800

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.

V1.110526

COVERED SERVICES

SERVICE	$1,250 PPO		$2,200 PPO		$3,500 PPO	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Office & Outpatient Physician Office Visits (PCP & Specialist)						
Primary Care Physician	$50 Copay	$50 Copay + 40% Coinsurance	$50 Copay	$50 Copay + 40% Coinsurance	$50 Copay	$50 Copay + 40% Coinsurance
Specialist Office Visit *No Referral Needed*	$75 Copay	$75 Copay + 40% Coinsurance	$75 Copay	$75 Copay + 40% Coinsurance	$75 Copay	$75 Copay + 40% Coinsurance
Chiropractic Care *12 Visits/Benefit Plan Year Maximum*	$60 Copay	$60 Copay + 40% Coinsurance	$60 Copay	$60 Copay + 40% Coinsurance	$60 Copay	$60 Copay + 40% Coinsurance
Urgent Care Office Visit	$90 Copay	$90 Copay + 40% Coinsurance	$90 Copay	$90 Copay + 40% Coinsurance	$90 Copay	$90 Copay + 40% Coinsurance
Surgery Performed in Office	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery
Therapies (Rehabilitation/Habilitation) *16 Visits/Benefit Year maximum combined: cardiac and occupational, speech, and respiratory*	$150 Copay/Visit After Deductible	$150 Copay/Visit +40% Coinsurance After Deductible	$150 Copay/Visit After Deductible	$150 Copay/Visit +40% Coinsurance After Deductible	$150 Copay/Visit After Deductible	$150 Copay/Visit +40% Coinsurance After Deductible
Therapies *16 Visits/Benefit Year Combined - ABA & TMS. Pre-certification Required.*	$150 Copay/Visit After Deductible	$150 Copay/Visit +40% Coinsurance After Deductible	$150 Copay/Visit After Deductible	$150 Copay/Visit +40% Coinsurance After Deductible	$150 Copay/Visit After Deductible	$150 Copay/Visit +40% Coinsurance After Deductible
Preventive Care *Annual wellness exams, labs, immunizations. See preventive care guide.*	$0 Copay $0 Deductible	40% Coinsurance After Deductible	$0 Copay $0 Deductible	40% Coinsurance After Deductible	$0 Copay $0 Deductible	40% 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
Labs *Independent labs only*	$35 Copay	$35 Copay + 40% Coinsurance	$35 Copay	$35 Copay + 40% Coinsurance	$35 Copay	$35 Copay + 40% Coinsurance
X-Rays *Stand-alone radiology only*	$75 Copay	$75 Copay + 40% Coinsurance	$75 Copay	$75 Copay + 40% Coinsurance	$75 Copay	$75 Copay + 40% Coinsurance
Diagnostic Testing/Advanced Imaging *Pre-certification Required.*	$500 Copay After Deductible	$500 Copay + 40% Coinsurance After Deductible	$500 Copay After Deductible	$500 Copay + 40% Coinsurance After Deductible	$500 Copay After Deductible	$500 Copay + 40% Coinsurance After Deductible
Mental Health & Substance Abuse						
Outpatient Office Visit	$75 Copay	$75 Copay + 40% Coinsurance	$75 Copay	$75 Copay + 40% Coinsurance	$75 Copay	$75 Copay + 40% Coinsurance

COVERED SERVICES

SERVICE	$1,250 PPO		$2,200 PPO		$3,500 PPO	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Inpatient *Same as inpatient hospital care, including limits. Pre-certification Required.*	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible
Mental Health / Substance Use Disorder – Partial Hospitalization (PHP)/ Intensive Outpatient Program (IOP)	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible
Mental Health / Substance Use Disorder – Residential Treatment *21 Days/Benefit Plan Year*	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible
Emergency Services						
Emergency Room Care *Any provider for true medical emergencies, no OON penalty.*	$1,000 Copay After Deductible	$1,000 Copay + 40% Coinsurance After Deductible	$1,000 Copay After Deductible	$1,000 Copay + 40% Coinsurance After Deductible	$1,000 Copay After Deductible	$1,000 Copay + 40% Coinsurance After Deductible
Ambulance **Land & Air** *2/Benefit Plan Year, land and air combined. OON ambulance claims processed in compliance with the No Surprises Act (NSA).*	$500 Copay After Deductible $1,000 Copay After Deductible	$500 Copay After Deductible $1,000 Copay After Deductible	$500 Copay After Deductible $1,000 Copay After Deductible	$500 Copay After Deductible $1,000 Copay After Deductible	$500 Copay After Deductible $1,000 Copay After Deductible	$500 Copay After Deductible $1,000 Copay After Deductible
Observation Room	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible	$1,000 Copay After Deductible
Inpatient Hospital Services Pre-certification Required						
Inpatient Hospital Care Facility or Partial Hospitalization	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible
Inpatient Surgical Services *Surgeon's Charges*	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% Coinsurance After Deductible	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% Coinsurance After Deductible	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% Coinsurance After Deductible
Inpatient Skilled Nursing Facility *21 Days/Benefit Plan Year*	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible
Inpatient Rehabilitation Facility *14 Days/Benefit Plan Year*	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible	$125 Copay/Day After Deductible	$125 Copay/Day + 40% Coinsurance After Deductible
Hospice *30 Days/Lifetime*	$0 Copay After Deductible	40% Coinsurance After Deductible	$0 Copay After Deductible	40% Coinsurance After Deductible	$0 Copay After Deductible	40% Coinsurance After Deductible
Organ Transplant	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible

COVERED SERVICES

SERVICE	$1,250 PPO		$2,200 PPO		$3,500 PPO	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Outpatient Services Pre-certification Required						
Outpatient Surgical Services *Surgeon's Charges.*	$250 Copay/Service After Deductible	$250 Copay/Service + 40% Coinsurance After Deductible	$250 Copay/Service After Deductible	$250 Copay/Service + 40% Coinsurance After Deductible	$250 Copay/Service After Deductible	$250 Copay/Service + 40% Coinsurance After Deductible
Outpatient Surgical Facility Services *Applies to facility charges: outpatient hospital, surgery center, or office.*	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% Coinsurance After Deductible	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% Coinsurance After Deductible	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% Coinsurance After Deductible
Outpatient Chemotherapy & Radiotherapy *30 Days/Benefit Plan Year*	$350 Copay/Visit After Deductible	$350 Copay/Visit + 40% After Deductible	$350 Copay/Visit After Deductible	$350 Copay/Visit + 40% After Deductible	$350 Copay/Visit After Deductible	$350 Copay/Visit + 40% After Deductible
Infusion/Injection	$250 Copay/Visit After Deductible	$250 Copay/Visit + 40% Coinsurance After Deductible	$250 Copay/Visit After Deductible	$250 Copay/Visit + 40% Coinsurance After Deductible	$250 Copay/Visit After Deductible	$250 Copay/Visit + 40% Coinsurance After Deductible
Dialysis	$400 Copay After Deductible	$400 Copay + 40% Coinsurance After Deductible	$400 Copay After Deductible	$400 Copay + 40% Coinsurance After Deductible	$400 Copay After Deductible	$400 Copay + 40% Coinsurance After Deductible
Outpatient Labs *No pre-certification required.*	$100 Copay After Deductible	$100 Copay + 40% Coinsurance After Deductible	$100 Copay After Deductible	$100 Copay + 40% Coinsurance After Deductible	$100 Copay After Deductible	$100 Copay + 40% Coinsurance After Deductible
Associated/Incidental Inpatient & Outpatient Services *Anesthesia, pathology, physician services and other incurred services*	$250 Copay/Service After Deductible	$250 Copay/Service + 40% Coinsurance After Deductible	$250 Copay/Service After Deductible	$250 Copay/Service + 40% Coinsurance After Deductible	$250 Copay/Service After Deductible	$250 Copay/Service + 40% Coinsurance After Deductible
Maternity Services						
Routine Prenatal/Postnatal Care *Covered at 100% after deductible: office visits, lab work, radiology, prenatal/postnatal care. Genetic testing excluded*	$0 Copay	40% Coinsurance After Deductible	$0 Copay	40% Coinsurance After Deductible	$0 Copay	40% Coinsurance After Deductible
Delivery - Professional Services *Maternity copay applies at delivery, after the deductible.*	$500 Copay After Deductible	$500 Copay + 40% Coinsurance After Deductible	$500 Copay After Deductible	$500 Copay + 40% Coinsurance After Deductible	$500 Copay After Deductible	$500 Copay + 40% Coinsurance After Deductible
Delivery - Facility *Inpatient limits apply*	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% Coinsurance After Deductible

COVERED SERVICES

SERVICE	$1,250 PPO		$2,200 PPO		$3,500 PPO	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Other Covered Services						
Durable Medical Equipment (DME) *Pre-certification required over $750. 5 items/benefit plan year.*	$50 Copay/Item After Deductible	$50 Copay/Item + 40% Coinsurance After Deductible	$50 Copay/Item After Deductible	$50 Copay/Item + 40% Coinsurance After Deductible	$50 Copay/Item After Deductible	$50 Copay/Item + 40% Coinsurance After Deductible
Home Health Care Visits *10 Visits/Benefit Plan Year. Pre-certification Required*	$50 Copay/Visit After Deductible	$50 Copay/Visit + 40% Coinsurance After Deductible	$50 Copay/Visit After Deductible	$50 Copay/Visit + 40% Coinsurance After Deductible	$50 Copay/Visit After Deductible	$50 Copay/Visit + 40% Coinsurance After Deductible
Nutritional Counseling *1 Visit/Benefit Plan Year*	$0 Copay	40% Coinsurance After Deductible	$0 Copay	40% Coinsurance After Deductible	$0 Copay	40% Coinsurance After Deductible
Prosthetics *1 Item/Benefit Plan Year. Pre-certification Required.*	$500 Copay/Item After Deductible	$500 Copay/Item + 40% Coinsurance After Deductible	$500 Copay/Item After Deductible	$500 Copay/Item + 40% Coinsurance After Deductible	$500 Copay/Item After Deductible	$500 Copay/Item + 40% Coinsurance After Deductible
Allergy **Shots/Serums:** *12 visits/benefit plan year* **Visits/Testing:** *1 visit/benefit plan year*	$25 Copay After Deductible $50 Copay/Visit After Deductible	$25 Copay + 40% Coinsurance After Deductible $50 Copay/Visit + 40% Coinsurance After Deductible	$25 Copay After Deductible $50 Copay/Visit After Deductible	$25 Copay + 40% Coinsurance After Deductible $50 Copay/Visit + 40% Coinsurance After Deductible	$25 Copay After Deductible $50 Copay/Visit After Deductible	$25 Copay + 40% Coinsurance After Deductible $50 Copay/Visit + 40% Coinsurance After Deductible
All Other Covered Services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	20% Coinsurance After Deductible	40% Coinsurance After Deductible	20% Coinsurance After Deductible	40% Coinsurance After Deductible

PRESCRIPTION DRUGS

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

HERE

PPO FORMULARY

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

	INN	OON
Preventive *Generic or Brand (see formular)*	$0 Copay	40% Coinsurance After Deductible
Generic Drugs *Urgent care Rx and maintenance Rx. 30-day supply at retail pharmacies, then mail order required (see formulary)*	$00 Copay	40% Coinsurance After Deductible
Preferred Brand Name	PAP Available	PAP Available
Non-Preferred Brand Name	PAP Available	PAP Available
GLP-1 Medication	Not Covered	Not Covered
Specialty Drugs	PAP Available	PAP Available

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

	INN	OON
Generic Drugs *90 Day Supply Maintenance Medication*	$20 Copay	40% Coinsurance After Deductible
Preferred Brand Name	PAP Available	PAP Available
Non-Preferred Brand Name	PAP Available	PAP Available
GLP-1 Medication	Not Covered	Not Covered
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.

OTHER COVERED SERVICES

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

SERVICES NOT COVERED

- Acupuncture
- Biofeedback
- Bariatric Surgery
- Children's Dental Check-up
- Children's Eye Exam
  Except when qualified under preventive care
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care
  When Traveling Outside of U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Program
- Hearing Aids
- Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult)

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 will result in penalties, which may be a 50% reduction of allowed charges or denial of the 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.
- Coverage period: 9/1/2026 – 12/31/2027.
- 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

		$1,250 PPO	$2,200 PPO	$3,500 PPO
Ages 18-29	Employee	$389.00	$379.00	$359.00
	Employee + Spouse	$729.00	$719.00	$689.00
	Employee + Child(ren)	$719.00	$709.00	$679.00
	Family	$1,029.00	$979.00	$949.00
Ages 30-44	Employee	$409.00	$399.00	$379.00
	Employee + Spouse	$769.00	$749.00	$719.00
	Employee + Child(ren)	$759.00	$739.00	$709.00
	Family	$1,059.00	$1,019.00	$989.00
Ages 45-54	Employee	$429.00	$419.00	$399.00
	Employee + Spouse	$829.00	$809.00	$779.00
	Employee + Child(ren)	$819.00	$799.00	$769.00
	Family	$1,129.00	$1,099.00	$1,079.00
Ages 55-64	Employee	$459.00	$449.00	$429.00
	Employee + Spouse	$849.00	$839.00	$809.00
	Employee + Child(ren)	$829.00	$819.00	$799.00
	Family	$1,169.00	$1,129.00	$1,099.00