AHS: RELIANCE HEALTH CARE: PLAN A

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 options during open enrollment contact Member Services at AHS Plans by phone (866) 602-7069 . They can answer your questions regarding enrollment into your insurance plan.

Beginning January 1, 2026, you may get coverage information, common terms, and access to a provider directory on the plan you selected by visiting www.ahsplans.com or by calling Member Services at (866) 602-7069. This number will also be provided to you on your Plan ID Card, which will be mailed to your home address before the plan year begins on 01/01/2026.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Single Coverage: $2,600 In-Network/ $5,200 Out of Network** **Employee Plus Child: $3,700 In- Network $7,400 Out of Network** **Family Coverage: $5,200 In-Network $10,400 Out of Network**	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If family coverage is elected, the full family deductible amount must be met before the plan will begin paying at the plan participation level.
Are there services covered before you meet your deductible?	Yes. Standard **Preventive care** services are covered before you meet your deductible.	This plan covers some items and services even if you have not 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?	**Single Coverage: $6,000 In-Network/ $10,000 Out of Network** **Employee Plus Child: $9,000 In- Network $15,000 Out of Network** **Family Coverage: $12,000 In-Network $20,000 Out of Network** **Individual Embedded OOP: $6,000 In-Network $10,000 Out of Network**	The out-of-pocket limit is the most you could pay in a year for covered services. Embedded Out-Of-Pocket Maximum means if you have family coverage, any combination of covered family members may help meet the family Out-of-Pocket maximum. However, no one person will pay more than his or her embedded individual Out-Of-Pocket maximum amount. .

What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes	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. You can search for in-net network providers at www.ahsplans.com.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
	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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (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	No Cost	20% Coinsurance	Subject to Deductible
	Specialist visit	No Cost	20% Coinsurance	Subject to Deductible
	Preventive care/screening/ immunization	No cost; Deductible Waived	Not Covered	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Your plan has no OON benefits for preventative health services.
If you have a test	Diagnostic test (x-ray, blood work)	No Cost	20% Coinsurance	Subject to Deductible unless preventative services
	Imaging (CT/PET scans, MRIs)	No Cost	20% Coinsurance	Subject to Deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.smithrx.com or by calling 844-454-5201.	Generic drugs (Tier 1)	30-day supply $15 at Heartland Pharmacies -or- $30 at In-Network Pharmacies; after deductible is met.	If you use a non-network pharmacy, you are responsible for payment upfront.	Member out-of-pocket applies up to a 90-day supply at Heartland Pharmacy Network; covers up to a 30-day specialty supply. *All specialty medications are limited to 30-day supply, specialty formulary and specialty network only. Out-of-network pharmacies are limited to a 30-day supply. *If members are eligible to receive a subsidy through a manufacturer copay program, the copayment under the Variable Copay Program will be equal to the maximum subsidy available through that manufacturer copay program. You must pay the difference in cost between a generic drug and brand-name drug plus the standard copay amount when a medical professional has not specified a brand-name drug or has not indicated that the brand-name drug is necessary, until the out-of-pocket is met.
	Preferred brand drugs (Tier 2)	30-day supply $30 at Heartland Pharmacies -or- $60 at In-Network Pharmacies; after deductible is met.	If you use a non-network pharmacy, you are responsible for payment upfront.	
	Non-preferred brand drugs (Tier 3)	30-day supply $45 at Heartland Pharmacies -or- $90 at In-Network Pharmacies; after deductible is met.	If you use a non-network pharmacy, you are responsible for payment upfront.	
	Specialty drugs (Tier 4)	10% Coinsurance	If you use a non-network pharmacy, you are responsible for payment upfront.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Cost	20% Coinsurance	Subject to Deductible
	Physician/surgeon fees	No Cost	20% Coinsurance	Subject to Deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need immediate medical attention	Emergency room care	No Cost	No Cost	In network deductible applies to out-of-network benefits. Services provided at a freestanding emergency room are excluded unless use is due to a life-threatening event. If covered, services are subject to out-of-network benefits.
	Emergency medical transportation	No Cost	No Cost	Subject to Deductible
	Urgent care	No Cost	20% Coinsurance	Subject to Deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	No Cost	20% Coinsurance	Preauthorization is required for hospitalization.
	Physician/surgeon fee	No Cost	20% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No Cost	20% Coinsurance	Preauthorization is required for hospitalization.
	Inpatient services	No Cost	20% Coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you are pregnant	Office visits	No cost	20% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).OON Services subject to deductible.
	Childbirth/delivery professional services	No Cost	20% Coinsurance	
	Childbirth/delivery facility services	No Cost	20% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No Cost	20% Coinsurance	90 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	No Cost	20% Coinsurance	Subject to deductible. Cardiac Pulmonary Phase 1 & 2 - 20 visit limit Cardiac Rehabilitation – 36 visit limit Cognitive Rehabilitation – 20 visit limit
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No Cost	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required.
	Durable medical equipment	No Cost	20% Coinsurance	Preauthorization is required for DME more than $500 for rentals or $1,500 for purchases.
	Hospice service	No Cost	20% Coinsurance	Subject to Deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- 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
- Cosmetic surgery (when medically necessary)
- Non-emergency care when traveling outside the U.S.

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 Standard? **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 1-866-576-7160.

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

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-family** **$5,200**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$10,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,200**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible-single** **$2,600**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$5,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible-single** **$2,600**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$7,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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