

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Jim Ellis Atlanta, Inc. – PPO High Medical Plan

Coverage Period: January 01, 2026 - December 31, 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, www.novahealthcare.com. 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 www.healthcare.gov/sbc-glossary or call 1-855-206-1040 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$5,000 individual / \$10,000 family for In-Network providers \$10,000 individual / \$20,000 family for Out-of-Network providers	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 primary care services 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 ?	\$9,100 individual / \$18,200 family for In-Network providers \$18,200 individual / \$27,300 family for Out-of-Network providers	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-billed charges, Pre-Certification penalties and healthcare this plan does not 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. See CIGNA Provider Directory or call 1-855-206-1040 for a list of participating 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 .
Is Pre-Certification required for services?	Yes, for certain services.	Failure to obtain precertification will result in a 100% penalty.



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 providers Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
	Specialist visit	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
	Preventive care/screening/immunization	No charge	Subject to deductible, then 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.
If you have a test	Diagnostic test (x-ray, blood work)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pbdrx.com	Generic Drugs/ Tier 1	Select Network: \$5 copay Non-Select Network: \$25 copay	Not covered	Must use a participating pharmacy. Retail: 30-day supply
	Preferred Brand Drugs/Tier 2	Select Network: \$25 copay Non-Select Network: \$45 copay	Not covered	Prior Authorization may be required for certain medications.
	Non-Preferred Brand Drugs/ Tier 3	Select Network: \$50 copay Non-Select Network: \$70 copay	Not covered	For verification call 1-888- 388-8228.
	Specialty drugs	Not covered	Not covered	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required
	Hospital fee & physician/surgeon fees	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required
If you need immediate medical attention	Emergency room care	\$750 copay/visit	\$750 copay/visit	Copay waived if admitted
	Emergency medical transportation	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
	Urgent care	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization is required
	Physician/surgeon fee			Prior Authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient and inpatient services	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
		Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Prior Authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network providers Provider	Out-of-Network Provider	
If you are pregnant	Office visits	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	None
	Childbirth/delivery facility services	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	Pre-certification is required for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay in order to avoid a penalty.
If you need help recovering or have other special health needs	Home health care	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	50 visits per calendar year; Prior Authorization required.
	Rehabilitation services			20 visits per calendar year
	Habilitation services			20 visits per calendar year
	Skilled nursing care			160 visits per calendar year; Prior Authorization required
	Durable medical equipment			None
	Hospice services			None
If your child needs dental or eye care	Children's eye exam or glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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 • Bariatric surgery • Dental Care • Infertility Treatment • Long Term Care	• Non-emergency care when traveling outside the U.S. • Routine Eye Care • Routine Foot Care • Weight Loss Programs	• Specialty medications for the treatment of cystic fibrosis, hemophilia, and spine bifida, unless it is administered at an inpatient setting or transplant related.
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic Care (limited to: 20 visits per calendar year)	• Hearing Aids (limited to: 1 per ear every 3 years; \$3000 max)	

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: 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.

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 the plan at 1-855-206-1040. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. "Additionally, a consumer assistance program can help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner." A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers> and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 1-855-206-1040

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-206-1040

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-206-1040

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.
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Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$5,000	■ The plan's overall deductible	\$5,000	■ The plan's overall deductible	\$5,000
■ Specialist [cost sharing]	Deductible	■ Specialist [cost sharing]	Deductible	■ Specialist [cost sharing]	Deductible \$465
■ Hospital (facility) [cost sharing]	\$4,100	■ Hospital (facility) [cost sharing]	Deductible	■ Hospital ER [cost sharing]	\$750
■ Other [cost sharing]	\$0	■ Other [cost sharing]	\$0	■ Other [cost sharing]	Deductible \$150
This EXAMPLE event includes services like: Specialist office initial visit (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$35,600	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$5,000	Deductibles	\$5,000	Deductibles	\$615
Copayments	n/a	Copayments	n/a	Copayments	\$750
Coinsurance	\$4,100	Coinsurance	\$116	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$9,100	The total Joe would pay is	\$5,136	The total Mia would pay is	\$1,365

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-206-1040.

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.