AMERUS SUMMIT
HEALTH PLANS

HEALTH COVERAGE WITH CONFIDENCE

PHCS

Straightforward coverage for the people who matter most.

A clear overview of plan benefits, member costs, monthly rates, and important plan details.

$0 DEDUCTIBLE

$4,000 / $8,000 OOP MAX

COVERAGE FOR INDIVIDUALS AND FAMILIES | PLAN: PHCS

AMERUS SUMMIT HEALTH PLANS

Your plan at a glance

Core benefits and monthly coverage rates

$0 / $0 PHCS

Individual / family deductible

$4,000 / $8,000 PHCS

Individual / family out-of-pocket max

MONTHLY COVERAGE RATES

Select the coverage tier that fits your household.

I	**Individual** MONTHLY	**$482.95**
S	**Individual + spouse** MONTHLY	**$737.08**
C	**Individual + child(ren)** MONTHLY	**$756.01**
F	**Family** MONTHLY	**$960.42**

WHAT TO KNOW

Deductible: $0 individual / $0 family.

Coinsurance: the member share is 40% and the carrier share is 60% for services listed with coinsurance.

Copays apply to the office, urgent-care, emergency-room and basic-laboratory benefits shown in this brochure.

Out-of-pocket maximum: $4,000 individual / $8,000 family.

Service limits: certain facility, emergency and diagnostic benefits include the day or yearly limits shown on the following pages.

Prescriptions: discount card only.

Monthly rates are separate from covered-service cost sharing. Refer to enrollment materials for effective dates.

Complete benefit reference

Office, facility, emergency, laboratory and imaging benefits

CARE AND FACILITY SERVICES

Office visits, urgent care and facility care

SERVICE	MEMBER COST	DETAILS
Primary care visit	**$50 copay**	Per visit
Specialist visit	**$75 copay**	Per visit
Urgent care	**$75 copay**	Per visit
Inpatient hospitalization	**40%**	5 days
Outpatient facility	**40%**	2 services/year

DIAGNOSTICS AND EMERGENCY

Laboratory, imaging and emergency-room care

SERVICE	MEMBER COST	DETAILS
Basic laboratory	**$50 copay**	Basic labs
Laboratory	**40%**	3 services/year
X-ray	**40%**	3 services/year
Imaging (MRI / CT)	**40%**	2 services/year
Emergency room	**$500 copay + 40%**	Copay deductible waived; 2/year

PLAN QUICK GUIDE

Deductible: $0 individual / $0 family.

Out-of-pocket max: $4,000 individual / $8,000 family.

Coinsurance: 40% member / 60% carrier.

PRESCRIPTION COVERAGE

Generic / preferred / non-preferred: Discount card only.

This is a discount program rather than an insured prescription benefit. Review the card materials for participating pharmacies and discount terms.

BENEFIT LIMITS

Limits shown in days or services apply to the listed benefit.

The emergency-room copay has the deductible waived. Confirm how the plan counts visits, days and services.

AMERUS SUMMIT HEALTH PLANS

Plan summary and important information

A concise reference for PHCS benefits, member costs and stated limits

Use this page as a quick reference. The official plan materials control all coverage determinations.

Plan cost sharing

Core individual / family amounts

Deductible	**$0 / $0**
Out-of-pocket max	**$4,000 / $8,000**
Member / carrier	**40% / 60%**
Prescriptions	**Discount card**

Office and urgent care

Fixed member copays

Primary care	**$50**
Specialist	**$75**
Urgent care	**$75**
Basic laboratory	**$50**

Facility and diagnostics

Member cost and stated limit

Inpatient	**40% | 5 days**
Outpatient facility	**40% | 2/year**
Emergency room	**$500 + 40% | 2/year**
Lab / X-ray	**40% | 3/year**
MRI / CT	**40% | 2/year**

IMPORTANT INFORMATION

About this brochure. This document is a convenient overview of the PHCS benefits and monthly rates. It is not the insurance contract. If this brochure differs from the official plan materials, the official materials control.

Benefit limits. Limits shown as days or services per year apply to the listed benefit. Confirm how the plan counts visits, days and services before receiving care.

Member costs. Copays and coinsurance are separate types of cost sharing.

Prescription notice. Generic, preferred and non-preferred medications are available through a discount card only. A discount card is not an insured prescription benefit.

Emergency room. The listed benefit is a $500 copay with the deductible waived, followed by 40% coinsurance, limited to 2 visits per year.

Before receiving care. Review the official plan materials for provider participation, authorization requirements, exclusions and complete benefit rules.