



PLAN COMPARISON:

Summary of Benefits & Coverage



Rates effective as of January 1, 2026

PPO in-network and out-of-network benefits

HSA \$3,500 Deductible

HSA \$5,000 Deductible

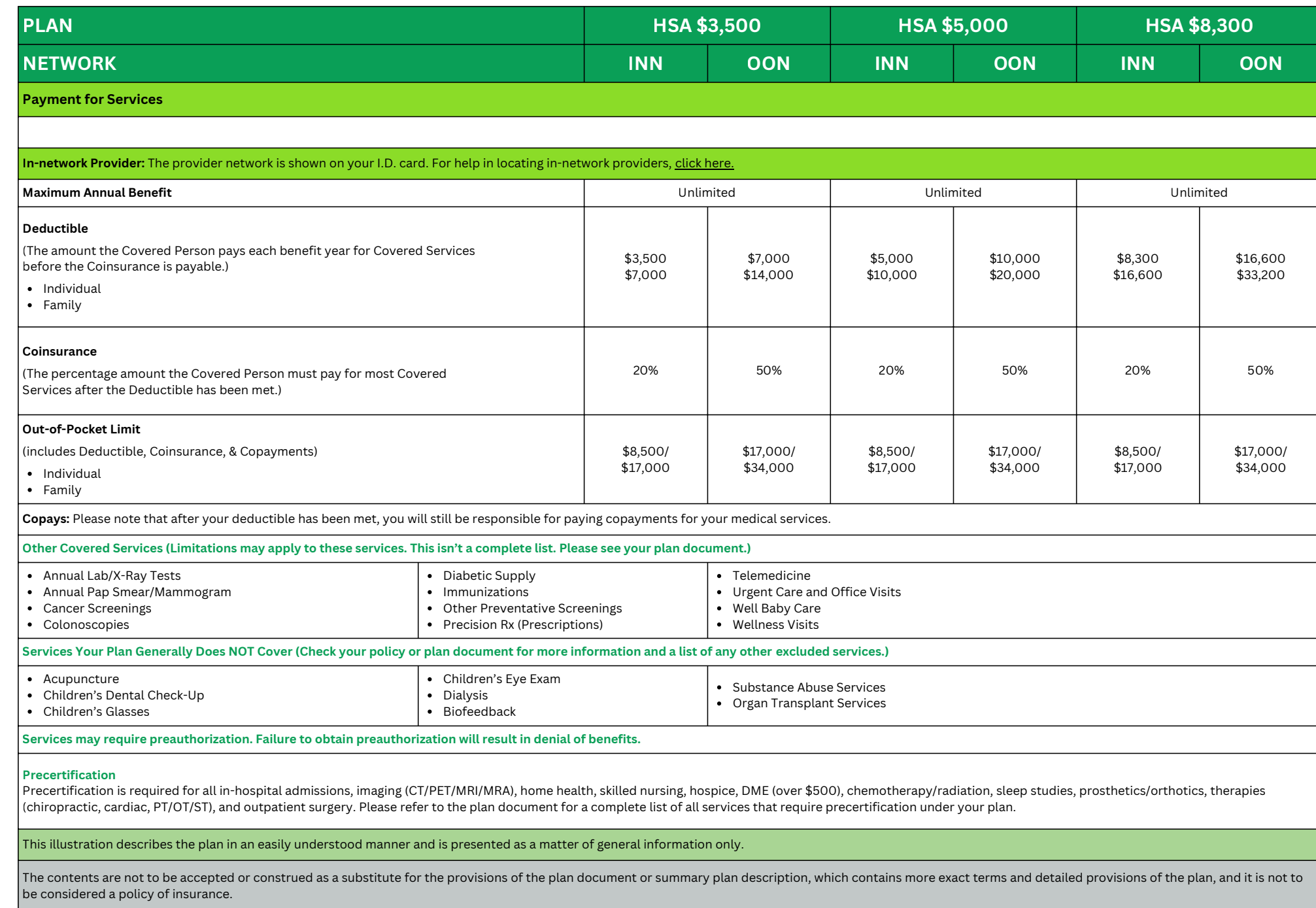
HSA \$8,300 Deductible

Network Options:

PHCS PPO or Cigna PPO

This plan is underwritten by Benefit Logistics Captive Insurance Co, Inc NAIC # 17633 and not by PHCS or Cigna Licensee.

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PLAN	HSA \$3,500		HSA \$5,000		HSA \$8,300	
NETWORK	INN	OON	INN	OON	INN	OON
Covered Services - Illness or Injury						
Physician Office Services - Primary Care Physician - Specialist Office Visit - No referral needed - Urgent Care Visit - Chiropractic Care(24 visits per calendar year)	Suggested Copay: \$40 20% After Deductible Suggested Copay: \$75 20% After Deductible Suggested Copay: \$90 20% After Deductible Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: \$40 20% After Deductible Suggested Copay: \$75 20% After Deductible Suggested Copay: \$90 20% After Deductible Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: \$40 20% After Deductible Suggested Copay: \$75 20% After Deductible Suggested Copay: \$90 20% After Deductible Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance
Telemedicine Through OurLiveDoc ONLY Primary and Urgent Care, Behavioral Health Call: 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay After Deductible Unlimited Visits	Not Covered	\$0 Copay After Deductible Unlimited Visits	Not Covered	\$0 Copay After Deductible Unlimited Visits	Not Covered
Emergency (Precertification is required within 48 hours of admission, if admitted)						
Emergency Services Please note that for a true medical emergency, any provider may be used. Emergency Ambulance Services Ground/Air Ambulance	Suggested Copay: \$1000 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: \$1000 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: \$1000 20% After Deductible	OON Deductible & Coinsurance
Labs	\$25 Copay After Deductible	OON Deductible & Coinsurance	\$25 Copay After Deductible	OON Deductible & Coinsurance	\$25 Copay After Deductible	OON Deductible & Coinsurance
X-rays	\$100 Copay After Deductible	OON Deductible & Coinsurance	\$100 Copay After Deductible	OON Deductible & Coinsurance	\$100 Copay After Deductible	OON Deductible & Coinsurance
Diagnostic Testing/Imaging (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Facility Services (Precertification Required) - Infusions/Injections - Outpatient Surgical Facility Services - Outpatient Chemotherapy and Radiotherapy - Dialysis (limited to acute temporary dialysis)	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered
Inpatient Hospital Services (Precertification Required) - Inpatient Hospital Care Facility - Inpatient Hospital Surgical Services - Inpatient Skilled Nursing Facility (30 days per calendar year maximum) - Inpatient Rehab Facility (30 days per calendar year maximum)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

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PLAN	HSA \$3,500		HSA \$5,000		HSA \$8,300	
NETWORK	INN	OON	INN	OON	INN	OON
Preventive Services - Click here for a complete list.						
Preventive Care/Screening/Immunization - Annual Adult Physical - Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria - Mammogram - Gynecological Services - Routine Colonoscopy - Well Child Care/Newborn Care	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance
Other Covered Services						
Therapy 35 days per benefit year maximum combined - Physical & Occupational Therapies - Speech Therapy - ABA & Respiratory	Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance
Pregnancy/Maternity - Prenatal/Postnatal Office Visit - Room and Board (limited to semi-private room rate)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Home Health Care (Precertification Required) 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Hospice Care (Precertification Required) 30 days per benefit year maximum Residential/Facility	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (DME) (Precertification Required) Limited to 12-month rental or purchase price, whichever is less.	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Allergy Testing/Injections	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

PLAN		HSA \$3,500		HSA \$5,000		HSA \$8,300	
NETWORK		INN	OON	INN	OON	INN	OON
Prescription Drugs							
Retail Pharmacy Copayments 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	Preventive Medicine Generic or Brand Name	\$0 Copay	OON Deductible & Coinsurance	\$0 Copay	OON Deductible & Coinsurance	\$0 Copay	OON Deductible & Coinsurance
	Generic Urgently Needed Care Rx	\$10 Copay After Deductible	OON Deductible & Coinsurance	\$10 Copay After Deductible	OON Deductible & Coinsurance	\$10 Copay After Deductible	OON Deductible & Coinsurance
	Generic Maintenance Rx	\$10 Copay After Deductible	OON Deductible & Coinsurance	\$10 Copay After Deductible	OON Deductible & Coinsurance	\$10 Copay After Deductible	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Urgently Needed Care Rx	\$90 Copay After Deductible	OON Deductible & Coinsurance	\$90 Copay After Deductible	OON Deductible & Coinsurance	\$90 Copay After Deductible	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Maintenance Rx	\$90 Copay After Deductible	OON Deductible & Coinsurance	\$90 Copay After Deductible	OON Deductible & Coinsurance	\$90 Copay After Deductible	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Urgently Needed Care Rx	\$110 Copay After Deductible	OON Deductible & Coinsurance	\$110 Copay After Deductible	OON Deductible & Coinsurance	\$110 Copay After Deductible	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Maintenance Rx	\$110 Copay After Deductible	OON Deductible & Coinsurance	\$110 Copay After Deductible	OON Deductible & Coinsurance	\$110 Copay After Deductible	OON Deductible & Coinsurance
	GLP1 Medication (For Qualifying Member, Not Covered for Weight Loss)	\$200 Copay	OON Deductible & Coinsurance	\$200 Copay	OON Deductible & Coinsurance	\$200 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments 90-day supply	Preventive Medicine Generic or Brand Name	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	Generic	\$20 Copay After Deductible	OON Deductible & Coinsurance	\$20 Copay After Deductible	OON Deductible & Coinsurance	\$20 Copay After Deductible	OON Deductible & Coinsurance
	Preferred Brand Name Drugs	\$180 Copay After Deductible	OON Deductible & Coinsurance	\$180 Copay After Deductible	OON Deductible & Coinsurance	\$180 Copay After Deductible	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs	\$220 Copay After Deductible	OON Deductible & Coinsurance	\$220 Copay After Deductible	OON Deductible & Coinsurance	\$220 Copay After Deductible	OON Deductible & Coinsurance
	GLP1 Medication (For Qualifying Members, Not Covered for Weight Loss)	\$600 Copay	OON Deductible & Coinsurance	\$600 Copay	OON Deductible & Coinsurance	\$600 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
RX Benefit Highlights							
RX Company		ProAct					
Phone		1-877-635-9545					
Website		https://secure.proactrx.com/					
Pharmacy Advantage Formulary		MM and HSA Formulary					
Telehealth and Mail Order Formulary		Telehealth and Mail Order Formulary					
Pharmacy Exclusions		Pharmacy Exclusions					
Additional Information		https://info.proactrx.com/welcome-lx-mm					

- Notes:**
- 1.Failure to obtain authorization will result in penalties. The penalty may be a 50% reduction of allowed charges or denial of claim.
 - 2.Elective Surgery will not be covered for the first 90 days of coverage.
 - 3.If you're facing a true emergency, such as severe injury or life-threatening symptoms, you may go to the closest emergency room with no out of network penalty or denial.
 - 4.In the case authorization is required for an emergency admission, there is a 48-hour grace period or next business day.

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PREMIUMS BY AGE BAND						
PLAN	HSA \$3,500		HSA \$5,000		HSA \$8,300	
NETWORK	PHCS	CIGNA	PHCS	CIGNA	PHCS	CIGNA
AGES 18-29						
Employee	\$543.00	\$604.00	\$527.00	\$588.00	\$449.00	\$499.00
Employee + Spouse	\$952.00	\$1,033.00	\$920.00	\$1,002.00	\$662.76	\$712.76
Employee + Child(ren)	\$872.00	\$954.00	\$843.00	\$925.00	\$743.06	\$793.06
Family	\$1,366.00	\$1,468.00	\$1,318.00	\$1,420.00	\$921.68	\$971.68
AGES 30-44						
Employee	\$559.00	\$620.00	\$542.00	\$603.00	\$499.00	\$549.00
Employee + Spouse	\$984.00	\$1,065.00	\$951.00	\$1,032.00	\$732.78	\$782.78
Employee + Child(ren)	\$901.00	\$982.00	\$871.00	\$952.00	\$821.60	\$871.60
Family	\$1,414.00	\$1,516.00	\$1,364.00	\$1,466.00	\$1,020.06	\$1,070.06
AGES 45-54						
Employee	\$584.00	\$645.00	\$566.00	\$627.00	\$519.00	\$569.00
Employee + Spouse	\$1,029.00	\$1,110.00	\$994.00	\$1,075.00	\$809.73	\$859.73
Employee + Child(ren)	\$941.00	\$1,023.00	\$910.00	\$992.00	\$908.87	\$958.87
Family	\$1,478.00	\$1,580.00	\$1,426.00	\$1,528.00	\$1,129.38	\$1,179.38
AGES 55-64						
Employee	\$620.00	\$681.00	\$601.00	\$662.00	\$559.00	\$609.00
Employee + Spouse	\$1,106.00	\$1,187.00	\$1,067.00	\$1,149.00	\$895.68	\$945.68
Employee + Child(ren)	\$1,010.00	\$1,092.00	\$976.00	\$1,058.00	\$1,005.83	\$1,055.83
Family	\$1,596.00	\$1,698.00	\$1,539.00	\$1,641.00	\$1,250.84	\$1,300.84