



Summary of Benefits & Coverage

EPO \$750/\$1,500 MM Deductible

Rates effective as of January 1, 2026
EPO in-network

Network Options:
CIGNA EPO

*This plan is underwritten by Benefit Logistic Captive Insurance Co, Inc NAIC #17633 and not by Cigna.

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Professional Services	PPO In-Network Benefits
In-network Provider: The provider network is shown on your I.D. card. For help locating in-network providers, click here .	
Deductible - Individual - Family	\$750 \$1,500
Out-of-Pocket Maximum - Including Deductible - Individual - Family	\$9,200 \$18,400
PCP Office Visit	\$50 Copay (After Deductible)
Specialist Office Visit (No Referral Needed)	\$50 Copay (After Deductible)
Urgent Care Office Visit	\$50 Copay (After Deductible)
Surgery Performed in the Office	See Outpatient Surgery
Chiropractic Care 12 visits per calendar year maximum	\$50 Copay (After Deductible)
Therapies: Physical, Speech, Occupational, Cardiac & Respiratory 16 visits per calendar year maximum combined	\$50 Copay/Visit (After Deductible)
Labs	\$25 Copay After Deductible
X-rays	\$50 Copay After Deductible
Diagnostic Testing/Advanced Imaging (Pre-certification Required)	\$200 Copay After Deductible
Telemedicine through OurLiveDoc ONLY Primary and Urgent Care, Behavioral Health Call: 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay Unlimited visits
Emergency Services (Pre-certification is required within 48 hours of admission, if admitted)	Participating Provider
Emergency Room Care Please note that for a true medical emergency, any provider may be used	\$1,000 Copay (After Deductible)
Ambulance	\$250 Copay (After Deductible)
Inpatient or Partial Hospitalization Services (Precertification Required)	Participating Provider
Inpatient Hospital Care Facility or Partial Hospitalization	\$2,500 Copay/Admission (After Deductible)
Inpatient Surgical Services	\$2,500 Copay/Surgery (After Deductible)
Associated/Incidental Inpatient Services (Includes Anesthesia, Pathology, Physician Services, and any other incurred services)	\$250 Copay/Service (After Deductible)
Inpatient Skilled Nursing Facility	\$50 Copay/Day (After Deductible)
Inpatient Rehabilitation Facility	\$50 Copay/Day (After Deductible)

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Hospice 30-day limit per Lifetime	\$0 Copay (After Deductible)
Organ Transplant	\$2,500 Copay/Admission (After Deductible)
Outpatient Services (Precertification Required)	Participating Provider
Outpatient Surgical Services (Outpatient Hospital, Surgery Center or Office)	\$2,500 Copay/Surgery (After Deductible)
Surgery Services (Includes surgeon, anesthesia, and any other incurred services associated with outpatient surgery)	\$250 Copay/Service (After Deductible)
Outpatient Chemotherapy and Radiotherapy	\$250 Copay/Visit (After Deductible)
Infusion / Injection	\$250 Copay/Visit (After Deductible)
Dialysis	\$250 Copay (After Deductible)
Outpatient Labs (No Pre-certification Required)	\$100 Copay (After Deductible)
Preventive Services	Participating Provider
Preventive Care Including but not limited to: Annual Wellness Exams, Labs and Immunizations See Preventative Care Guide	\$0 Copay \$0 Deductible
Maternity Services	Participating Provider
Pregnancy, Maternity - Routine Vaginal Delivery - Routine C-section Delivery - All other Maternity Service (Other maternity services included office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded Genetic testing unless medically necessary.)	\$2,500 Copay/Admission (After Deductible) \$2,500 Copay/Admission (After Deductible) 100% Covered
Other Covered Services	Participating Provider
Home Health Care Visits (Pre-certification Required) 10 visits per Benefit Year	\$50 Copay/Visit (After Deductible)
Durable Medical Equipment (DME) (Precertification Required) Copayment is applied per item received. 5 items /benefit period.	\$50 Copay/Item (After Deductible)
Diabetic Nutritional Counseling (1 visit per plan year)	\$0 Copay (After Deductible)
Prosthetics (Pre-certification Required) (1 item per Benefit Plan Year)	\$50 Copay/Item (After Deductible)

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Allergies • Shots • Visits/Testing		\$25 Copay (After Deductible)	
		\$50 Copay/Visit (After Deductible)	
Prescription Drugs			
Retail Pharmacy Copayments 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	Preventive Medicine Rx - Generic or Brand (See Formulary)		\$0 Copay
	Generic Drugs - Urgent Care Rx (See Formulary)		\$0 Copay
	Generic Drugs - Maintenance Rx (See Formulary)		\$0 Copay
	Preferred Brand Name Drugs		PAP Available
	Non-Preferred Brand Name Drugs		PAP Available
	Specialty Drugs		PAP Available
Mail Order or Retail Pharmacy Copayments 90-day supply maintenance medication	Generic Drugs (See Formulary)		\$0 Copay
	Preferred Brand Name Drugs		Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs		Patient Assistance Plans Available
	Specialty Drugs		Patient Assistance Plans Available
Rx Benefit Highlights			
Rx Company		ProAct	
Phone 24/7/365		1-877-635-9545	
Website		https://secure.proactrx.com/	
Formulary		https://bit.ly/4j9crFR	
Mail Order/Telehealth		https://bit.ly/4j9crFR	
Failure to obtain authorization will result in penalties. The penalty may be a 50% reduction of allowed charges or denial of claim.			
Elective Surgery will not be covered for the first 90 days of coverage.			
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.			
In the case authorization is required for an emergency admission, there is a 48-hour grace period or next business day.			
The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan, and it is not to be considered a policy of insurance			

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