

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.

Rates effective as of January 1, 2026



PLAN NETWORK		HSA \$3,500		HSA \$5,000		HSA \$8,300		
		INN	OON	INN	OON	INN	OON	
Payment for Services								
In-network Provider: The provider network is shown of	on your I.D. card. For help in locating in-net	work providers, <u>click</u>	chere.					
Maximum Annual Benefit		Unlimited		Unlimited		Unlimited		
Deductible								
(The amount the Covered Person pays each benefit y before the Coinsurance is payable.)	ear for Covered Services	\$3,500	\$7,000	\$5,000	\$10,000	\$8,300	\$16,600	
Individual		\$7,000	\$14,000	\$10,000	\$20,000	\$16,600	\$33,200	
• Family								
Coinsurance								
(The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.)		20%	50%	20%	50%	20%	50%	
Out-of-Pocket Limit								
includes Deductible, Coinsurance, & Copayments)		\$8,500/	\$17,000/	\$8,500/	\$17,000/	\$8,500/	\$17,000	
IndividualFamily		\$17,000	\$34,000	\$17,000	\$34,000	\$17,000	\$34,000	
Copays: Please note that after your deductible has be	een met, you will still be responsible for pay	ving copayments for	your medical services					
Other Covered Services (Limitations may apply to th	ese services. This isn't a complete list. Plea	se see your plan do	cument.)					
Annual Lab/X-Ray Tests	Diabetic Supply		Telemedicine					
Annual Pap Smear/MammogramCancer Screenings	ImmunizationsOther Preventative Scre	enings	Urgent Care and Office Visits Well Baby Care					
Colonoscopies	Precision Rx (Prescription	•	Well busy cure Wellness Visits					
Services Your Plan Generally Does NOT Cover (Checl	your policy or plan document for more in	formation and a list	of any other excluded	services.)				
Acupuncture	Children's Eye Exam		Substance Abuse Services					
Children's Dental Check-UpChildren's Glasses	DialysisBiofeedback		Organ Transplant Services					
Services may require preauthorization. Failure to ob	tain preauthorization will result in denial of	f benefits.						
Precertification								
Precertification Precertification is required for all in-hospital admission	ons, imaging (CT/PET/MRI/MRA), home healt	th, skilled nursing, ho	ospice, DME (over \$50	0), chemotherapy/ra	diation, sleep studies	. prosthetics/orthotic	cs. therapies	

This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.

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.

Rates effective as of January 1, 2026



PLAN	HSA \$	HSA \$3,500 HS		5,000	HSA \$8,300	
NETWORK	INN	OON	INN	OON	INN	OON
Covered Services - Illness or Injury						
Physician Office Services	Suggested Copay: \$40 20% After Deductible		Suggested Copay: \$40 20% After Deductible		Suggested Copay: \$40 20% After Deductible	
Primary Care Physician Specialist Office Visit	Suggested Copay: \$75 20% After Deductible	OON Deductible &	Suggested Copay: \$75 20% After Deductible	OON Deductible &	Suggested Copay: \$75 20% After Deductible	OON Deductible &
Urgent Care Visit Spinal Manipulation Chiropractic (24 visits per calendar year)	Suggested Copay: \$90 20% After Deductible	Coinsurance	Suggested Copay: \$90 20% After Deductible	Coinsurance	Suggested Copay: \$90 20% After Deductible	Coinsurance
maximum)	Suggested Copay: \$75 20% After Deductible		Suggested Copay: \$75 20% After Deductible		Suggested Copay: \$75 20% After Deductible	
Telemedicine Through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay After Deductible	Not Covered	\$0 Copay After Deductible	Not Covered	\$0 Copay After Deductible	Not Covered
Emergency (Precertification is required within 48 hours o	f 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)		OON Deductible & Coinsurance		OON Deductible & Coinsurance		OON Deductible & Coinsurance
Infusions/Injections Outpatient Surgical Facility Services	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Chemotherapy and Radiotherapy		Not Covered		Not Covered		Not Covered
Dialysis (limited to acute temporary dialysis)		Not Covered		Not Covered		Not Covered
Inpatient Services (Precertification Required)						
 Inpatient Hospital Care Facility Inpatient Hospital Surgical Services (All Fees) Intensive Care Unit Inpatient Rehabilitation 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

Rates effective as of January 1, 2025



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	100% of Allowable	\$0 Copay \$0 Deductible	100% of Allowable	\$0 Copay \$0 Deductible	100% of Allowable
Other Covered Services						
Therapy 35 days per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	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
Inpatient Skilled Nursing Facility (Precertification Required) 30-day visit limit per benefit year	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 (Precertification Required)	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Diabetic Nutritional Counseling (1 visit per plan year)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
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									
	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		
Retail Pharmacy Copayments	Generic Maintenance Rx	\$10 Copay After Deductible	OON Deductible & Coinsurance	\$10 Copay After Deductible	OON Deductible & Coinsurance	\$10 Copay After Deductible	OON Deductible & Coinsurance		
30-day supply at retail pharmacies	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		
Mail order required for maintenance medication after initial 30-day supply	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		
	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		
	Preventive Medicine Generic or Brand Name	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay		
Mail Order or Retail	Generic	\$20 Copay After Deductible	OON Deductible & Coinsurance	\$20 Copay After Deductible	OON Deductible & Coinsurance	\$20 Copay After Deductible	OON Deductible & Coinsurance		
Pharmacy Copayments	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		
90-day supply	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		
	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 Formula	ry	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.



		F	PREMIUMS BY AGE BANI				
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	
amily	\$1,596.00	\$1,698.00	\$1,539.00	\$1,641.00	\$1,250.84	\$1,300.84	