



PLAN COMPARISON:

Summary of Benefits & Coverage

Rates effective as of January 1, 2026

Network Options: CIGNA EPO (In-Network)



EPO \$500/\$1,000 MM Deductible

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

EPO \$1,000/\$2,000 MM Deductible

EPO \$1,500/\$3,000 MM Deductible

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PLAN	EPO \$500	EPO \$750	EPO \$1,000	EPO \$1,500
In-network Provider: The provider network is shown on your I.D. card. For help locating in-network providers, click here .				
Deductible - Individual - Family	\$500 \$1,000	\$750 \$1,500	\$1,000 \$2,000	\$1,500 \$3,000
Out of Pocket Maximum - Including Deductible - Individual - Family	\$9,200 \$18,400	\$9,200 \$18,400	\$9,200 \$18,400	\$9,200 \$18,400
PCP Office Visit	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
Specialist Office Visit (No Referral Needed)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
Urgent Care Office Visit	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
Surgery Performed in the Office	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery
Chiropractic Care 12 visits per calendar year maximum	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
Therapies: Physical, Speech, Occupational, Cardiac, & Resp 16 Visits per calendar year maximum combined	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)
Labs	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
X-rays	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay
Diagnostic Testing/Advanced Imaging (Pre-Certification Required)	\$200 Copay	\$200 Copay	\$200 Copay	\$200 Copay
Telemedicine through OurLiveDoc ONLY Primary and Urgent Care, Behavioral Health Call 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay Unlimited Visits	\$0 Copay Unlimited Visits	\$0 Copay Unlimited Visits	\$0 Copay Unlimited Visits
Emergency Services (Pre-certification is required within 48 hours of admission, if admitted)				
Emergency Room Care Please note that for a true medical emergency, any provider may be used.	\$1,000 Copay (After Deductible)	\$1,000 Copay (After Deductible)	\$1,000 Copay (After Deductible)	\$1,000 Copay (After Deductible)

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Ambulance	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)
Inpatient or Partial Hospitalization Services (Pre-certification Required)				
Inpatient Hospital Care Facility or Partial Hospitalization	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)
Inpatient Surgical Services	\$2,500 Copay/Surgery (After Deductible)	\$2,500 Copay/Surgery (After Deductible)	\$2,500 Copay/Surgery (After Deductible)	\$2,500 Copay/Surgery (After Deductible)
Associated/Incidental Inpatient Services (Includes Anesthesia, Pathology, Physician Services, and any other incurred services)	\$250 Copay/Surgery (After Deductible)	\$250 Copay/Surgery (After Deductible)	\$250 Copay/Surgery (After Deductible)	\$250 Copay/Surgery (After Deductible)
Inpatient Skilled Nursing Facility	\$50 Copay/Day (After Deductible)	\$50 Copay/Day (After Deductible)	\$50 Copay/Day (After Deductible)	\$50 Copay/Day (After Deductible)
Inpatient Rehabilitation Facility	\$50 Copay/Day (After Deductible)	\$50 Copay/Day (After Deductible)	\$50 Copay/Day (After Deductible)	\$50 Copay/Day (After Deductible)
Hospice 30-day limit per Lifetime	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)
Organ Transplant	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)
Outpatient Services (Pre-certification Required)				
Outpatient Surgical Services (Outpatient Hospital, Surgery Center, or Office)	\$2,500 Copay/Surgery (After Deductible)	\$2,500 Copay/Surgery (After Deductible)	\$2,500 Copay/Surgery (After Deductible)	\$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)	\$250 Copay/Service (After Deductible)	\$250 Copay/Service (After Deductible)	\$250 Copay/Service (After Deductible)
Outpatient Chemotherapy and Radiotherapy	\$250 Copay/Visit (After Deductible)	\$250 Copay/Visit (After Deductible)	\$250 Copay/Visit (After Deductible)	\$250 Copay/Visit (After Deductible)
Infusion / Injection	\$250 Copay/Visit (After Deductible)	\$250 Copay/Visit (After Deductible)	\$250 Copay/Visit (After Deductible)	\$250 Copay/Visit (After Deductible)

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Dialysis	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)	\$250 Copay (After Deductible)
Outpatient Labs (No Pre-certification Required)	\$100 Copay (After Deductible)	\$100 Copay (After Deductible)	\$100 Copay (After Deductible)	\$100 Copay (After Deductible)
Preventive Service				
Preventive Care including but not limited to: Annual Wellness Exams, Labs and Immunizations See Preventative Care Guide	\$0 Copay \$0 Deductible	\$0 Copay \$0 Deductible	\$0 Copay \$0 Deductible	\$0 Copay \$0 Deductible
Maternity Services				
Pregnancy, Maternity - Routine Vaginal Delivery - Routine C-Section Delivery - All other Maternity Service (Other maternity services including 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	\$2,500 Copay/Admission (After Deductible) \$2,500 Copay/Admission (After Deductible) 100% Covered	\$2,500 Copay/Admission (After Deductible) \$2,500 Copay/Admission (After Deductible) 100% Covered	\$2,500 Copay/Admission (After Deductible) \$2,500 Copay/Admission (After Deductible) 100% Covered
Other Covered Services	Participating Provider	Participating Provider	Participating Provider	Participating Provider
Home Health Care Visits (Pre-certification Required) 10 visits per Benefit Year	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)
Durable Medical Equipment (DME) (Pre-certification Required) Copayment is applied per item received. 5 items/benefit period.	\$50 Copay/Item (After Deductible)	\$50 Copay/Item (After Deductible)	\$50 Copay/Item (After Deductible)	\$50 Copay/Item (After Deductible)
Diabetic Nutritional Counseling (1 visit per Plan Year)	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)
Prosthetics (Pre-certification Required) (1 item per Benefit Plan Year)	\$50 Copay/Item (After Deductible)	\$50 Copay/Item (After Deductible)	\$50 Copay/Item (After Deductible)	\$50 Copay/Item (After Deductible)
Allergies - Shots - Visits/Testing	\$25 Copay (After Deductible) \$50 Copay/Visit (After Deductible)	\$25 Copay (After Deductible) \$50 Copay/Visit (After Deductible)	\$25 Copay (After Deductible) \$50 Copay/Visit (After Deductible)	\$25 Copay (After Deductible) \$50 Copay/Visit (After Deductible)

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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	\$0 Copay	\$0 Copay	\$0 Copay
	Generic Drugs - Urgent Care Rx (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	Generic Drugs - Maintenance Rx (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	Preferred Brand Name Drugs	PAP Available	PAP Available	PAP Available	PAP Available
	Non-Preferred Brand Name Drugs	PAP Available	PAP Available	PAP Available	PAP Available
	Specialty Drugs	PAP Available	PAP Available	PAP Available	PAP Available
Mail Order or Retail Pharmacy Copayments 90-day supply maintenance medication	Generic Drugs (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	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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