



# Summary of Benefits & Coverage

**\$750/\$1,500 Deductible**

Rates effective as of January 1, 2026  
PPO In-Network

Network Options:  
First Health PPO

\*This plan is underwritten by Benefit Re, Inc NAIC #17459 and not by any network.

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Professional Services	PPO In-Network Benefits	Out-Of-Network What Member Pays
<b>In-network Provider:</b> The provider network is shown on your I.D. card. For help locating in-network providers, <a href="#">click here</a> .		
<b>Deductible</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$750 \$1,500	\$750 \$1,500
<b>Out-of-Pocket Maximum - Including Deductible</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$9,200 \$18,400	\$9,200 \$18,400
<b>PCP Office Visit</b>	\$50 Copay (After Deductible)	Copay + 10% After Deductible
<b>Specialist Office Visit</b> (No Referral Needed)	\$50 Copay (After Deductible)	Copay + 10% After Deductible
<b>Urgent Care Office Visit</b>	\$50 Copay (After Deductible)	Copay + 10% After Deductible
<b>Surgery Performed in the Office</b>	See Outpatient Surgery	Copay + 10% After Deductible
<b>Chiropractic Care</b> 12 visits per calendar year maximum	\$50 Copay (After Deductible)	Copay + 10% After Deductible
<b>Therapies:</b> Physical, Speech, Occupational, Cardiac & Respiratory 16 visits per calendar year maximum combined	\$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible
<b>Labs</b> (Independent Lab Only)	\$25 Copay (After Deductible)	Copay + 10% After Deductible
<b>X-rays</b> (Stand Alone Radiology Only)	\$50 Copay (After Deductible)	Copay + 10% After Deductible
<b>Diagnostic Testing/Advanced Imaging</b> (Pre-certification Required)	\$200 Copay After Deductible	Copay + 10% After Deductible
<b>Telemedicine through OurLiveDoc ONLY</b> <b>Primary and Urgent Care, Behavioral Health</b> Call: 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay Unlimited visits	Copay + 10% After Deductible
<b>Emergency Services</b> (Pre-certification is required within 48 hours of admission, if admitted)	Participating Provider	Non-Participating Provider
<b>Emergency Room Care</b> Please note that for a true medical emergency, any provider may be used	\$1,000 Copay (After Deductible)	Copay + 10% After Deductible
<b>Ambulance - Land</b> <b>Ambulance - Air</b> (2 per Benefit Plan Year Combined)	\$250 Copay (After Deductible) \$1,000 Copay (After Deductible)	Copay + 10% After Deductible
<b>Inpatient or Partial Hospitalization Services</b> (Precertification Required)	Participating Provider	Non-Participating Provider
<b>Inpatient Hospital Care Facility or Partial Hospitalization</b>	\$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible
<b>Inpatient Surgical Services</b>	\$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
<b>Associated/Incidental Inpatient Services</b> (Includes Anesthesia, Pathology, Physician Services, and any other incurred services)	\$250 Copay/Service (After Deductible)	Copay + 10% After Deductible
<b>Inpatient Skilled Nursing Facility</b>	\$50 Copay/Day (After Deductible)	Copay + 10% After Deductible
<b>Inpatient Rehabilitation Facility</b>	\$50 Copay/Day (After Deductible)	Copay + 10% After Deductible

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<b>Hospice</b> 30-day limit per Lifetime	\$0 Copay (After Deductible)	Copay + 10% After Deductible
<b>Organ Transplant</b>	\$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible
<b>Outpatient Services</b> (Precertification Required)	Participating Provider	Non-Participating Provider
<b>Outpatient Surgical Services</b> (Outpatient Hospital, Surgery Center or Office)	\$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
<b>Surgery Services</b> (Surgeon, anesthesia, and any other incurred services associated with outpatient surgery)	\$250 Copay/Service (After Deductible)	Copay + 10% After Deductible
<b>Outpatient Chemotherapy and Radiotherapy</b>	\$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible
<b>Infusion / Injection</b>	\$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible
<b>Dialysis</b>	\$250 Copay (After Deductible)	Copay + 10% After Deductible
<b>Outpatient Labs</b> (No Pre-certification Required)	\$100 Copay (After Deductible)	Copay + 10% After Deductible
<b>Preventive Services</b>	Participating Provider	Non-Participating Provider
<b>Preventive Care</b> Including but not limited to: Annual Wellness Exams, Labs and Immunizations <a href="#">See Preventative Care Guide</a>	\$0 Copay \$0 Deductible	Copay + 10% After Deductible
<b>Maternity Services</b>	Participating Provider	Non-Participating Provider
<b>Pregnancy, Maternity</b> <ul style="list-style-type: none"> <li>Routine Delivery (Vaginal or C-Section)</li> <li>All other Routine Maternity Service (Including office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded Genetic testing unless medically necessary.)</li> </ul>	\$2,500 Copay/Admission (After Deductible)  100% Covered	Copay + 10% After Deductible
<b>Other Covered Services</b>	Participating Provider	Non-Participating Provider
<b>Home Health Care Visits</b> (Pre-certification Required) 10 visits per Benefit Year	\$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible
<b>Durable Medical Equipment (DME)</b> (Precertification Required) Copayment is applied per item received. 5 items /benefit period.	\$50 Copay/Item (After Deductible)	Copay + 10% After Deductible
<b>Diabetic Nutritional Counseling</b> (1 visit per plan year)	\$0 Copay (After Deductible)	Copay + 10% After Deductible
<b>Prosthetics</b> (Pre-certification Required) (1 item per Benefit Plan Year)	\$50 Copay/Item (After Deductible)	Copay + 10% After Deductible
<b>All other Covered Services</b>	90% After Deductible	Copay + 10% After Deductible

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<b>Allergies</b> <ul style="list-style-type: none"> <li>• Shots/Serum</li> <li>• Visits/Testing</li> </ul>	\$25 Copay (After Deductible)  \$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	
<b>Prescription Drugs</b>	Participating Provider	Non-Participating Provider	
<b>Retail Pharmacy Copayments</b>  30-day supply at retail pharmacies  Mail order required for maintenance medication after initial 30-day supply	<b>Preventive Medicine Rx - Generic or Brand</b> (See Formulary)	\$0 Copay	Copay + 10% After Deductible
	<b>Generic Drugs - Urgent Care Rx</b> (See Formulary)	\$0 Copay	Copay + 10% After Deductible
	<b>Generic Drugs - Maintenance Rx</b> (See Formulary)	\$0 Copay	Copay + 10% After Deductible
	<b>Preferred Brand Name Drugs</b>	PAP Available	Not Covered
	<b>Non-Preferred Brand Name Drugs</b>	PAP Available	Not Covered
	<b>Specialty Drugs</b>	PAP Available	Not Covered
<b>Mail Order or Retail Pharmacy Copayments</b>  90-day supply maintenance medication	<b>Generic Drugs</b> (See Formulary)	\$0 Copay	Copay + 10% After Deductible
	<b>Preferred Brand Name Drugs</b>	Patient Assistance Plans Available	Not Covered
	<b>Non-Preferred Brand Name Drugs</b>	Patient Assistance Plans Available	Not Covered
	<b>Specialty Drugs</b>	Patient Assistance Plans Available	Not Covered
<b>Rx Benefit Highlights</b>			
<b>Rx Company</b>	ProAct		
<b>Phone 24/7/365</b>	1-877-635-9545		
<b>Website</b>	<a href="https://secure.proactrx.com/">https://secure.proactrx.com/</a>		
<b>Formulary</b>	<a href="#">Formulary</a>		
<b>Mail Order/Telehealth</b>	<a href="#">Mail Order/Telehealth</a>		

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