



# Summary of Benefits & Coverage

## HSA \$8,300 Deductible

Rates effective as of January 1, 2026  
PPO in-network and out-of-network benefits

Network Options:  
PHCS PPO

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

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NETWORK	INN	OON
<b>Payment for Services</b>		
<b>In-network Provider:</b> The provider network is shown on your I.D. card. For help in locating in-network providers, <a href="#">click here</a> .		
<b>Maximum Annual Benefit</b>	UNLIMITED	
<b>Deductible</b> (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$8,300 \$16,600	\$16,600 \$33,200
<b>Coinsurance</b> (The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.)	20%	50%
<b>Out-of-Pocket Limit</b> (includes Deductible, Coinsurance, & Copayments) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$8,500 \$17,000	\$17,000 \$34,000
<b>Copays:</b> Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.		
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"> <li>Annual Lab/X-Ray Tests</li> <li>Annual Pap Smear/Mammogram</li> <li>Cancer Screenings</li> <li>Colonoscopies</li> </ul>	<ul style="list-style-type: none"> <li>Diabetic Supply</li> <li>Immunizations</li> <li>Other Preventative Screenings</li> <li>Precision Rx (Prescriptions)</li> </ul>	<ul style="list-style-type: none"> <li>Telemedicine (including Mental Health Services)</li> <li>Urgent Care and Office Visits</li> <li>Well Baby Care</li> <li>Wellness Visits</li> </ul>
<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Children's Dental Check-Up</li> <li>Children's Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Children's Eye Exam</li> <li>Dialysis</li> <li>Biofeedback</li> </ul>	<ul style="list-style-type: none"> <li>Mental Health Services (except for Telemedicine)</li> <li>Substance Abuse Services</li> <li>Organ Transplant Services</li> </ul>
<b>Services may require preauthorization. Failure to obtain preauthorization will result in denial of benefits.</b>		
<b>Precertification</b> Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over \$500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan.		
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.		

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NETWORK	INN	OON
<b>Covered Services - Illness or Injury</b>		
<b>Physician Office Services</b> <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialist Office Visit                             <ul style="list-style-type: none"> <li>No referral needed</li> </ul> </li> <li>Urgent Care Visit</li> <li>Chiropractic Care(24 visits per calendar year)</li> </ul>	<p>Suggested Copay: \$40 20% After Deductible</p> <p>Suggested Copay: \$75 20% After Deductible</p> <p>Suggested Copay: \$90 20% After Deductible</p> <p>Suggested Copay: \$75 20% After Deductible</p>	OON Deductible & Coinsurance
<b>Telemedicine</b> Through OurLiveDoc ONLY  <b>Primary and Urgent Care, Behavioral Health</b> Call: 940-LIVE-DOC (940-548-3362) to get started	<p>\$0 Copay after deductible</p> <p>Unlimited Visits</p>	Not Covered
<b>Emergency (Precertification is required within 48 hours of admission, if admitted)</b>		
<b>Emergency Room Care</b> Please note that for a true medical emergency, any provider may be used.  Emergency Ambulance Services <ul style="list-style-type: none"> <li>Ground/Air Ambulance</li> </ul>	<p>Suggested Copay: \$1000 20% After Deductible</p>	OON Deductible & Coinsurance
<b>Labs</b>	\$25 Copay After Deductible	OON Deductible & Coinsurance
<b>X-rays</b>	\$100 Copay After Deductible	OON Deductible & Coinsurance
<b>Diagnostic Testing/Advanced Imaging</b> (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
<b>Outpatient Facility Services</b> (Precertification Required) <ul style="list-style-type: none"> <li>Infusions/Injections</li> <li>Outpatient Surgical Facility Services</li> <li>Outpatient Chemotherapy and Radiotherapy</li> <li>Dialysis (limited to acute temporary dialysis)</li> </ul>	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered
<b>Inpatient Hospital Services</b> (Precertification Required) <ul style="list-style-type: none"> <li>Inpatient Hospital Care Facility</li> <li>Inpatient Hospital Surgical Services</li> <li>Inpatient Skilled Nursing Facility (30 days per calendar year maximum)</li> <li>Inpatient Rehab Facility (30 days per calendar year maximum)</li> </ul>	20% After Deductible	OON Deductible & Coinsurance

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NETWORK	INN	OON
<b>Preventive Services - <a href="#">Click here for a complete list.</a></b>		
<b>Preventive Care/Screening/Immunization</b> <ul style="list-style-type: none"> <li>Annual Adult Physical</li> <li>Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria</li> <li>Mammogram</li> <li>Gynecological Services</li> <li>Routine Colonoscopy</li> <li>Well Child Care/Newborn Care</li> </ul>	\$0 Copay \$0 Deductible	OON Deductible & Coinsurance
<b>Other Covered Services - Illness or Injury</b>		
<b>Therapy</b> 35 days per benefit year maximum combined <ul style="list-style-type: none"> <li>Physical &amp; Occupational Therapies</li> <li>Speech Therapy</li> <li>ABA &amp; Respiratory</li> </ul>	Suggested Copay: \$75 20% After Deductible	OON Deductible & Coinsurance
<b>Pregnancy/Maternity</b> <ul style="list-style-type: none"> <li>Prenatal/Postnatal Office Visit</li> <li>Room and Board (limited to semi-private room rate)</li> </ul>	20% After Deductible	OON Deductible & Coinsurance
<b>Home Health Care</b> 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
<b>Hospice Care</b> 30 days per benefit year maximum <ul style="list-style-type: none"> <li>Residential/Facility</li> </ul>	20% After Deductible	OON Deductible & Coinsurance
<b>Durable Medical Equipment (DME)</b> Limited to 12-month rental or purchase price, whichever is less	20% After Deductible	OON Deductible & Coinsurance
<b>Organ Transplant</b>	20% After Deductible	Not Covered
<b>Allergy Testing/Injections</b>	20% After Deductible	OON Deductible & Coinsurance

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

**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	
NETWORK	PHCS
<b>AGES 18-29</b>	
Employee	\$449.00
Employee + Spouse	\$662.76
Employee + Child(ren)	\$743.06
Family	\$921.68
<b>AGES 30-44</b>	
Employee	\$499.00
Employee + Spouse	\$732.78
Employee + Child(ren)	\$821.60
Family	\$1,020.06
<b>AGES 45-54</b>	
Employee	\$519.00
Employee + Spouse	\$809.73
Employee + Child(ren)	\$908.87
Family	\$1,129.38
<b>AGES 55-64</b>	
Employee	\$559.00
Employee + Spouse	\$895.68
Employee + Child(ren)	\$1,005.83
Family	\$1,250.84