



# Summary of Benefits & Coverage

**MM \$1,000 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>	\$1,000 \$2,000	\$2,000 \$4,000
<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>	\$10,600 \$21,200	\$20,300 \$40,600
<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</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>• 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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<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                             <ul style="list-style-type: none"> <li>24 visits per plan year</li> </ul> </li> </ul>	\$25 Copay \$40 Copay \$60 Copay \$30 Copay	OON Deductible & Coinsurance
<b>Telemedicine-</b> Through OurLiveDoc ONLY Primary and Urgent Care, Behavioral Health Call: 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay Unlimited Visits	Not Covered
<b>Emergency (Precertification is required within 48 hours of admission, if admitted)</b>		
<b>Emergency Room Care</b> Precertification Required <ul style="list-style-type: none"> <li>Please note that for a true medical emergency, any provider may be used.</li> <li>Emergency Ambulance Services                             <ul style="list-style-type: none"> <li>Ground/Air Ambulance</li> </ul> </li> </ul>	20% After Deductible	OON Deductible & Coinsurance
<b>Surgery Performed In Office</b>	20% After Deductible	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 (30 days per plan year)</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 Services</b> (Precertification Required) <ul style="list-style-type: none"> <li>Inpatient Hospital Care Facility</li> <li>Inpatient Hospital Surgical Services, All Fees</li> <li>Intensive Care Unit (30 days per plan year)</li> <li>Inpatient Rehabilitation Facility (30 days per plan year)</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</b>		
<b>Therapies</b> 30 visits per plan year combined <ul style="list-style-type: none"> <li>Physical &amp; Occupational Therapies</li> <li>Speech Therapy</li> <li>ABA &amp; Respiratory</li> </ul>	\$40 Copay	OON Deductible & Coinsurance
<b>Pregnancy/Maternity</b> <ul style="list-style-type: none"> <li>Prenatal/Postnatal Office Visit</li> <li>Room and Board</li> </ul>	20% After Deductible	OON Deductible & Coinsurance
<b>Home Health Care Visits</b> (Precertification required) 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
<b>Inpatient Hospice Care</b> (Precertification required) 30 days per benefit year maximum <ul style="list-style-type: none"> <li>Residential/Facility</li> </ul>	20% After Deductible	OON Deductible & Coinsurance
<b>Inpatient Skilled Nursing Facility</b> (Precertification required) 30-day visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
<b>Durable Medical Equipment (DME)</b> (Precertification required) Limited to 12-month rental or purchase price, whichever is less	20% After Deductible	OON Deductible & Coinsurance
<b>Organ Transplant</b> (Precertification required)	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>	\$0 Copay	OON Deductible & Coinsurance
	<b>Generic</b> Urgently Needed Care Rx	\$10 Copay	OON Deductible & Coinsurance
	<b>Generic</b> Maintenance Rx	\$10 Copay	OON Deductible & Coinsurance
	<b>Preferred Brand Name Drugs</b> Urgently Needed Care Rx	\$90 Copay	OON Deductible & Coinsurance
	<b>Preferred Brand Name Drugs</b> Maintenance Rx	\$90 Copay	OON Deductible & Coinsurance
	<b>Non-Preferred Brand Name Drugs</b> Urgently Needed Care Rx	\$110 Copay	OON Deductible & Coinsurance
	<b>Non-Preferred Brand Name Drugs</b> Maintenance Rx	\$110 Copay	OON Deductible & Coinsurance
	<b>GLP1 Medication</b> (For Qualifying Members, 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>Generic</b>	\$20 Copay	OON Deductible & Coinsurance
	<b>Preferred Brand Name Drugs</b>	\$180 Copay	OON Deductible & Coinsurance
	<b>Non-Preferred Brand Name Drugs</b>	\$220 Copay	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	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>Pharmacy Advantage 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>		

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PREMIUMS BY AGE BAND	
NETWORK	PHCS
<b>AGES 18-29</b>	
Employee	\$811.00
Employee + Spouse	\$1,436.00
Employee + Child(ren)	\$1,322.00
Family	\$2,069.00
<b>AGES 30-44</b>	
Employee	\$837.00
Employee + Spouse	\$1,487.00
Employee + Child(ren)	\$1,368.00
Family	\$2,145.00
<b>AGES 45-54</b>	
Employee	\$875.00
Employee + Spouse	\$1,556.00
Employee + Child(ren)	\$1,431.00
Family	\$2,245.00
<b>AGES 55-64</b>	
Employee	\$969.00
Employee + Spouse	\$1,744.00
Employee + Child(ren)	\$1,601.00
Family	\$2,526.00