SUMMARY OF BENEFITS & COVERAGE

Deductible

3,500 / $7,000

Rates Effective As of January 1, 2026

COPAY

PPO COPAY PLAN

CIGNA

NETWORK

PPO

INN & OON BENEFITS

PLAN AT A GLANCE	*INN*	*OON*
Individual Deductible	$3,500	$7,000
Family Deductible	$7,000	$14,000
Individual Out-of-Pocket Max	$9,200	$9,200
Family Out-of-Pocket Max	$18,400	$18,400

Bright Life Health & Wellness

COVERED SERVICES

SERVICE	*INN*	*OON*
Office & Outpatient		
Physician Office Visits (PCP & Specialist)		
Primary Care Physician	$50 Copay Before Deductible	$50 Copay + 40% Before Deductible
Specialist Office Visit *No Referral Needed*	$75 Copay Before Deductible	$75 Copay + 40% Before Deductible
Chiropractic Care *12 Visits/Calendar Year*	$60 Copay Before Deductible	$60 Copay + 40% Before Deductible
Urgent Care Office Visit	$90 Copay Before Deductible	$50 Copay + 40% Before Deductible
Surgery Performed In Office	See Outpatient Surgery	See Outpatient Surgery
Therapies *16 Visits/ Calendar Year Combined - Physical, Occupational, Speech, ABA, Cardiac & Respiratory*	$150 Copay/Visit After Deductible	$150 Copay/Visit + 40% After Deductible
Telemedicine - Our Live Doc ***ONLY*** *Virtual Primary Care & Virtual Urgent Care: 940-LIVEDOC (940-548-3362)* *Behavioral Health: 866-890-3741*	$0 Copay Unlimited Visits	Not Covered
Emergency & Ambulance *- Precertification Required within 48 hours, if admitted*		
Emergency Room Care ***Any provider for true medical emergencies*	$1,000 Copay After Deductible	$1,000 Copay + 40% After Deductible
Ambulance *Land* *Air: 2/Benefit Plan Year Combined*	$250 Copay After Deductible $1,000 Copay After Deductible	$500 Copay + 40% After Deductible $1,000 Copay + 40% After Deductible
Diagnostics		
Diagnostic Testing / Advanced Imaging *Pre-certification Required*	$500 Copay After Deductible	$500 Copay + 40% After Deductible
Labs *Independent Labs Only*	$35 Copay	$35 Copay + 40% Coinsurance
X-Rays *Stand Alone Radiology Only*	$75 Copay	$75 Copay + 40% Coinsurance
Outpatient Services *- Pre-certification Required*		
Outpatient Surgical Facility Services *Outpatient Hospital, Surgery Center, or Office*	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% After Deductible
Outpatient Chemotherapy & Radiotherapy	$350 Copay/Visit After Deductible	$350 Copay/Visit + 40% After Deductible

Notes

- 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.

Bright Life Health & Wellness

SERVICE	INN	OON
Infusion / Injection	$250 Copay/Visit After Deductible	$250 Copay/Visit + 40% After Deductible
Outpatient Labs *No Pre-certification Required*	$100 Copay After Deductible	$100 Copay + 40% After Deductible
Dialysis	$400 Copay After Deductible	$400 Copay +40% After Deductible
Surgery Services *Surgeon, Anesthesia, and any Other Incurred Services Associated with Outpatient Surgery*	$250 Copay/Service After Deductible	$250 Copay/Service + 40% 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 + 40% After Deductible
Inpatient Surgical Services	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 40% After Deductible
Inpatient Skilled Nursing Facility *21 Day Limit*	$125 Copay/Day After Deductible	$125 Copay/Day + 40% After Deductible
Inpatient Rehabiliation Facility *14 Day Limit*	$125 Copay/Day After Deductible	$125 Copay/Day + 40% After Deductible
Organ Transplant	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 40% After Deductible
Hospice *30 Day Limit Per Lifetime*	$0 Copay After Deductible	$0 Copay + 40% After Deductible
Associated/Incidental Inpatient Services *Anesthesia, Pathology, Physician Services, and Any Other Incurred Services*	$250 Copay/Service After Deductible	$250 Copay/Service + 40% After Deductible
Preventative Services		
Preventative Care *Including but Not Limited to: Annual Wellness Exams, Labs, Immunizations. See Preventative Care Guide*	$0 Copay $0 Deductible	$0 Copay + 40% $0 Deductible
Maternity Services *- Pregnancy, Maternity*		
Routine Delivery *Vaginal or C-Section*	$2,500 Copay/Admission After Deductible	$2,500 + 40% Copay/Admission After Deductible
All Other Routine Maternity Service *Including Office Visits, Lab Work, Radiology, Prenatal/Postnatal Care, etc. Excluded Genetic Testing Unless Medically Necessary.*	100%	100%

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SERVICE	*INN*	*OON*
Other Covered Services		
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 + 40% After Deductible
Home Health Care Visits *Pre-certification Required* *10 Visits per Benefit Year*	$50 Copay/Visit After Deductible	$50 Copay/Visit + 40% After Deductible
Diabetic Nutritional Counseling *1 Visit/Plan Year*	$0 Copay After Deductible	$0 Copay + 40% After Deductible
Prosthetics *Pre-certification Required. 1 Item/Benefit Plan Year*	$500 Copay/Item After Deductible	$500 Copay/Item + 40% After Deductible
Allergies *Shots/Serums*	$25 Copay After Deductible	$25 Copay + 40% After Deductible
Visits/Testing	$50 Copay/Visit After Deductible	$50 Copay/Visit + 40% After Deductible
All Other Covered Services	80% After Deductible	70% After Deductible

Notes

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- In the case authorization is required for an emergency admission, there is a 48-hour grace period or next business day.

OTHER COVERED SERVICES

- Annual Lab / X-Ray Tests
- Annual Pap Smear / Mammogram
- Colonoscopies
- Cancer Screenings
- Diabetic Supply
- Immunizations
- Telemedicine
- Other Preventive Screenings
- Well Baby Care
- Wellness Visits
- Urgent Care & Office Visits

SERVICES NOT COVERED

- Acupuncture
- Biofeedback
- Children’s Glasses
- Children’s Dental Check-Up
- Children’s Eye Exam
- Dialysis
- Organ Transplant Services

PRE-AUTHORIZATION REQUIRED

Pre-certification 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. ***Failure to obtain pre-certification will result in denial of benefits.*** *Emergencies are covered but require authorization within 48 hours.*

PRESCRIPTION DRUGS

Managed by ProAct - 1-888-250-8032 - secure.proactrx.com - see formulary. 30 day retail supply; mail order required for maintenance medication after initial 30 day fill.

HERE

FORMULARY

HERE

TELEHEALTH / MAIL ORDER FORMULARY

HERE

PHARMACY EXCLUSIONS

RETAIL PHARMACY *- See Formulary*

	INN	*OON*
Preventive Medicine Rx *Generic or Brand (See Formulary)*	$0 Copay	$0 Copay + 40% After Deductible
Generic Drugs - Urgent Care Rx *30 Day-Supply at Retail Pharmacies. (See Formulary)*	$0 Copay	$0 Copay + 40% After Deductible
Generic Drugs - Maintenance Rx *30 Day-Supply at Retail Pharmacies. Mail Order Required for Maintenance Medication after Initial 30 Day-Supply. (See Formulary)*	$0 Copay	$0 Copay + 40% After Deductible
Preferred Brand Name	PAP Available	PAP Available
Non-Preferred Brand Name	PAP Available	PAP Available
Specialty Drugs	PAP Available	PAP Available

PRESCRIPTION DRUGS

Managed by ProAct - 1-888-250-8032 - secure.proactrx.com - see formulary. 30 day retail supply; mail order required for maintenance medication after initial 30 day fill.

MAIL ORDER / RETAIL PHARMACY

	INN	*OON*
Generic Drugs *90 Day Supply Maintenance Medication (See Formulary)*	$0 Copay	$0 Copay + 40% After Deducitlbe
Preferred Brand Name	PAP Available	PAP Available
Non-Preferred Brand Name	PAP Available	PAP Available
Specialty Drugs	PAP Available	PAP Available

KEY DEFINITIONS

- **Deductible**: The amount you pay each benefit year for covered services before coinsurance kicks in.
- **Out-of-Pocket Maximum**: The most you'll ever be required to pay for covered services in a benefit year.
- **Copay**: Your fixed payment at the time of service. Copays still apply after your deductible is met
- I**n-Network Provider**: Providers within the PHCS PPO network shown on your ID Card. Always confirm status before scheduling care.

MONTHLY PREMIUMS BY AGE

Ages 18-29

Employee	$359.00
Employee + Spouse	$689.00
Employee + Child(ren)	$679.00
Family	$949.00

Ages 30-44

Employee	$379.00
Employee + Spouse	$719.00
Employee + Child(ren)	$709.00
Family	$989.00

Ages 45-54

Employee	$399.00
Employee + Spouse	$779.00
Employee + Child(ren)	$769.00
Family	$1,079.00

Ages 55-64

Employee	$429.00
Employee + Spouse	$809.00
Employee + Child(ren)	$799.00
Family	$1,099.00

This document is a summary for general information purposes only.

It is not a substitute for the official plan document or summary plan description, and does not constitute as a policy of insurance. Please refer to the full plan document for complete terms, limitations, and benefit details.

PREVENTIVE CARE GUIDE

Adult Wellness

SCREENINGS / COUNSELING / MEDICATIONS

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ***ever*** smoked.
2. Alcohol misuse screening and counseling.
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
4. Blood pressure screening.
5. Cholesterol screening for adults of certain ages or at higher risk.
6. Colorectal cancer screening for adults 45 to 75.
7. Depression Screening
8. Diabetes (Type 2) screening for adults 40 to 70 years who are overweight.
9. Diet counseling for adults at higher risk for chronic disease.
10. Fall prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. Hepatitis C screening for adults aged 18 to 79 years.
13. HIV screening for everyone aged 15 to 65, and other ages at increased risk.
14. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
15. Lung cancer screening for adults 50 to 80 at high risk for lung cancer due to heavy smoking or who have quit in the past 15 years.
16. Obesity screening and counseling.
17. Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
18. Statin preventive medication for adults 40 to 75 at high risk.
19. Syphilis screening for adults at higher risk.
20. Tobacco use screening for all adults and cessation interventions for tobacco users.
21. Tuberculosis screening for certain adults without symptoms at high risk.

IMMUNIZATIONS / VACCINES: Dosage, Age, Recommended Populations Vary

Chickenpox (Varicella)	Human Papillomavirus (HPV)	Pneumococcal
Diphtheria	Measles	Rubella
Flu (Influenza)	Meningococcal	Shingles
Hepatitis A	Mumps	Tetanus
Hepatitis B	Whooping Cough (Pertussis)	

PREVENTIVE CARE GUIDE CONT.

Women's Wellness

SCREENING / TESTING

Services for pregnant women or women who may become pregnant.

1. Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies for pregnant and nursing women.
2. Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity.
3. Folic acid supplements for women who may become pregnant.
4. Gestational diabetes screening for women 24 weeks pregnant(or later) and those at high risk of developing gestational diabetes.
5. Gonorrhea screening for all women at higher risk.
6. Hepatitis B screening for pregnant women at their first prenatal visit.
7. Maternal depression screening for mothers at well-baby visits.
8. Preeclampsia prevention and screening for pregnant women with high blood pressure.
9. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
10. Syphilis screening.
11. Expanded tobacco intervention and counseling for pregnant tobacco users.
12. Urinary tract or other infection screening.
13. Screening for interpersonal and domestic violence.

Other covered preventive services for women.

1. Bone density screening for all women over age 65 or women aged 64 and younger who have gone through menopause.
2. Breast cancer genetic test counseling (BRCA)for women at higher risk
3. Breast cancer mammography screenings every 2 years for women 50 and over, and as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
4. Breast cancer chemoprevention counseling for women at higher risk
5. Cervical cancer screening.
6. Pap test (also called a Pap smear)for women 21 to 65.
7. Chlamydia infection screening for younger women and other women at higher risk.
8. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
9. Domestic and interpersonal violence screening and counseling for all women.
10. Gonorrhea screening for all women at higher risk.
11. HIV screening and counseling for everyone aged 15 to 65, and other ages at increased risk.
12. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use.
13. Sexually transmitted infection counseling for sexually active women.
14. Tobacco use screening and interventions.
15. Urinary incontinence screening for women yearly
16. Well-woman visits to get recommended services for all women

PREVENTIVE CARE GUIDE CONT.

Newborn / Child Care Wellness

SCREENINGS / ASSESSMENTS / SUPPLEMENTS

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children: Age 0 to 11 months,1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children: Age 0 to 11 months,1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
6. Blood screening for newborns
7. Depression screening for adolescents beginning routinely at age 12
8. Developmental screening for children under age 3
9. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
10. Fluoride supplements for children without fluoride in their water source
11. Fluoride varnish for all infants and children as soon as teeth are present
12. Gonorrhea preventive medication for the eyes of all newborns
13. Hearing screening for all newborns; regular screenings for children and adolescents as recommended by their provider
14. Height, weight, and body mass index (BMI) measurements taken regularly for all children
15. Hematocrit or hemoglobin screening for all children
16. Hemoglobinopathies or sickle cell screening for newborns
17. Hepatitis B screening for adolescents at higher risk
18. HIV screening for adolescents at higher risk
19. Hypothyroidism screening for newborns
20. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
21. Lead screening for children at risk of exposure
22. Obesity screening and counseling
23. Oral health risk assessment for young children from 6 months to 6 years
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
26. Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months,1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
27. Vision screening for all children
28. Well-baby and well-child visits

IMMUNIZATIONS / VACCINES: Dosage, Age, Recommended Populations Vary

Chickenpox (Varicella)	Human Papillomavirus (HPV)	Poliovirus (inactive)
Diphtheria, tetanus, & pertussis (DTaP)	Flu (Influenza)	Measles,Mumps & Rubella (MMR)
Haemophilus influenzae (B)	Meningococcal	Rotavirus
Hepatitis A & B	Pneumococcal	Tetanus