SUMMARY OF BENEFITS & COVERAGE

HSA

HEALTH SAVINGS ACCOUNT

CIGNA

NETWORK

PPO

INN & OON BENEFITS

HSA Plan Comparison

Rates Effective As of September 1, 2026

PLAN AT A GLANCE	*INN*	*OON*
Individual Deductible	$5,500-$8,500	$11,000 - $17,000
Family Deductible	$11,000 - $17,000	$22,000 - $34,000
Individual Out-of-Pocket Max	$8,500	$17,000
Family Out-of-Pocket Max	$17,000	$34,000

COVERED SERVICES

SERVICE	$5,500 HSA		$8,500 HSA	
	INN	*OON*	*INN*	*OON*
Office & Outpatient				
Physician Office Visits (PCP & Specialist)				
Primary Care Physician	Suggested Copay: $40 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: $40 20% After Deductible	OON Deductible & Coinsurance
Specialist Office Visit *No Referral Needed*	Suggested Copay: $75 20% After Deductible		Suggested Copay: $75 20% After Deductible	
Chiropractic Care *24 Visits/Calendar Year*	Suggested Copay: $75 20% After Deductible		Suggested Copay: $75 20% After Deductible	
Urgent Care Office Visit	Suggested Copay: $90 20% After Deductible		Suggested Copay: $90 20% After Deductible	
Therapies *35 Day/Benefit Year Maximum Combined* *Physical & Occupational, Speech, ABA & Respiratory*	Suggested Copay: $75 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: $75 20% After Deductible	OON Deductible & Coinsurance
Telemedicine - Our Live Doc ONLY *Virtual Primary Care & Virtual Urgent Care:* *940-LIVEDOC (940-548-3362)* *Behavioral Health: 866-890-3741*	$0 Copay After Deductible Unlimited Visits	Not Covered	$0 Copay After Deductible Unlimited Visits	Not Covered
Emergency & Ambulance *- Pre-certification Required within 48 hours, if admitted*				
Emergency Room Care ***Any provider for true medical emergencies*	Suggested Copay: $1,000 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: $1,000 20% After Deductible	OON Deductible & Coinsurance
Ambulance *Land* *Air*	Suggested Copay: $1,000 20% After Deductible	OON Deductible & Coinsurance	Suggested Copay: $1,000 20% After Deductible	OON Deductible & Coinsurance
Diagnostics				
Diagnostic Testing / Advanced Imaging *Pre-certification Required*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

Bright Life Health & Wellness

COVERED SERVICES

SERVICE	$5,500 HSA		$8,500 HSA	
	INN	*OON*	*INN*	*OON*
Diagnostics Continued				
Independent Labs	$25 Copay After Deductible	OON Deductible & Coinsurance	$25 Copay After Deductible	OON Deductible & Coinsurance
X-Rays	$100 Copay After Deductible	OON Deductible & Coinsurance	$100 Copay After Deductible	OON Deductible & Coinsurance
Outpatient Facility *- Pre-certification Required*				
Infusions/Injections	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Surgical Facility Services	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Chemotherapy & Radiotherapy	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Dialysis *Limited to acute temporary dialysis*	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Inpatient Hospital Services *- Pre-certification Required*				
Inpatient Hospital Care Facility	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Hospital Surgical Services	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility *30 Days/Calendar Year Maximum*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Rehabilitation Facility *30 Days/Calendar Year Maximum*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Hospice Care *Residential/Facility* *30 Days/Benefit Year Maximum*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

COVERED SERVICES

SERVICE	$5,500 HSA		$8,500 HSA	
	INN	*OON*	*INN*	*OON*
Preventative Services				
Preventative Care / Screening / Immunizations *Annual Adult Physical, Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria, Mammogram, Gynecological Services, Routine Colonoscopy, Well Child Care/Newborn Care*	$0 Copay $0 Deductible	OON Deductible & Coinsurance	$0 Copay $0 Deductible	OON Deductible & Coinsurance
Maternity Services *- Pregnancy, Maternity*				
Prenatal / Postnatal Office Visit / Delivery	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Room and Board *Limited to semi-private room rate*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services *- Injury or Illness*				
Durable Medical Equipment (DME) *Limited to 12-month rental or purchase price, whichever is less*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Home Health Care Visits *60 Visit Limit/Benefit Year*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Allergy Testing / Injections	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

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.

OTHER COVERED SERVICES

- Cancer Screenings
- Annual Pap Smear / Mammogram
- Colonoscopies
- Diabetic Supply
- Other Preventive Screenings
- Well Baby Care

SERVICES NOT COVERED

- Acupuncture
- Biofeedback
- Children’s Glasses
- Children’s Eye Exam
- Children’s Dental Check-Up

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 Verus - 1-800-838-0007 - verus-rx.com

HERE

HSA FORMULARY

RETAIL PHARMACY

- See Formulary

	INN	*OON*
Preventive Medicine Rx *Generic or Brand*	$0 Copay	OON Deductible & Coinsurance
Generic *Urgently Needed Care Rx & Maintenance Rx*	$10 Copay After Deductible	OON Deductible & Coinsurance
Preferred Brand Name *Urgently Needed Care Rx & Maintenance Rx*	$90 Copay After Deductible	OON Deductible & Coinsurance
Non-Preferred Brand Name *Urgently Needed Care Rx & Maintenance Rx*	$110 Copay After Deductible	OON Deductible & Coinsurance
GLP1 Medication *For Qualifying Member Not Covered for Weight Loss*	$200 Copay After Deductible	OON Deductible & Coinsurance
Specialty Drugs	PAP Available	PAP Available

**30-Day Supply at Retail Pharmacies*
Mail Order Required for Maintenance Medication After Initial 30-Day Supply

PRESCRIPTION DRUGS

Managed by Verus - 1-800-838-0007 - verus-rx.com

MAIL ORDER / RETAIL PHARMACY *- See Formulary*

	INN	*OON*
Preventive Medicine *Generic or Brand Name*	$0 Copay	OON Deductible & Coinsurance
Generic	$20 Copay After Deductible	OON Deductible & Coinsurance
Preferred Brand Name	$180 Copay After Deductible	OON Deductible & Coinsurance
Non-Preferred Brand Name	$220 Copay After Deductible	OON Deductible & Coinsurance
GLP1 Medication *For Qualifying members* *Not Covered for Weight Loss*	$600 Copay After Deductible	OON Deductible & Coinsurance
Specialty Drugs	PAP Available	PAP Available

**90-Day Supply*

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
- **In-Network Provider**: Providers within the PHCS PPO network shown on your ID Card. Always confirm status before scheduling care.

MONTHLY PREMIUMS BY AGE

		$5,500	*$8,500*
Ages **18-29**	**Employee**	$514.00	$454.00
	Employee + Spouse	$909.00	$669.00
	Employee + Child(ren)	$834.00	$734.00
	Family	$1,239.00	$889.00
Ages **30-44**	**Employee**	$534.00	$484.00
	Employee + Spouse	$939.00	$839.00
	Employee + Child(ren)	$864.00	$824.00
	Family	$1,289.00	$949.00
Ages **45-54**	**Employee**	$564.00	$514.00
	Employee + Spouse	$989.00	$909.00
	Employee + Child(ren)	$904.00	$884.00
	Family	$1,349.00	$1,059.00
Ages **55-64**	**Employee**	$604.00	$554.00
	Employee + Spouse	$1,079.00	$1,009.00
	Employee + Child(ren)	$974.00	$984.00
	Family	$1,459.00	$1,169.00

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