SUMMARY OF BENEFITS & COVERAGE

MM

MAJOR MEDICAL PLAN

CIGNA

NETWORK

INN & OON

BENEFITS

MM Plan Comparison

Rates Effective As of September 1, 2026

PLAN AT A GLANCE	*INN*	*OON*
Individual Deductible	$2,500 - $8,100	$5,000 - $16,200
Family Deductible	$5,000 - $16,200	$10,000 - $32,400
Coinsurance	20%	30%
Individual Out-of-Pocket Max	$10,600	$20,300
Family Out-of-Pocket Max	$21,200	$40,600
Annual Maximum Benefit	Unlimited	Unlimited

Bright Life Health & Wellness

COVERED SERVICES

SERVICE	$2,500 MM		$5,300 MM		$8,100 MM	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Office & Outpatient						
Physician Office Visits (PCP & Specialist)						
Primary Care Physician	$50 Copay		$50 Copay		$50 Copay	
Specialist Office Visit *No Referral Needed*	$60 Copay	OON Deductible & Coinsurance	$60 Copay	OON Deductible & Coinsurance	$60 Copay	OON Deductible & Coinsurance
Chiropractic Care *18 Visits/Calendar Year*	$50 Copay		$50 Copay		$50 Copay	
Urgent Care Office Visit	$75 Copay		$75 Copay		$75 Copay	
Surgery Performed In Office	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Therapies *20 Visits/Year Combined - Physical, Occupational, Speech, ABA & Respiratory*	$100 Copay	OON Deductible & Coinsurance	$100 Copay	OON Deductible & Coinsurance	$100 Copay	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 Unlimited Visits	Not Covered	$0 Copay Unlimited Visits	Not Covered	$0 Copay Unlimited Visits	Not Covered
Emergency & Ambulance *- Pre-certification Required within 48 hours, if admitted*						
Emergency Room Care ***Any provider for true medical emergencies*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Ambulance	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
Diagnostics						
Diagnostic Testing / Advanced Imaging *Pre-certification Required*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

COVERED SERVICES

SERVICE	$2,500 MM		$5,300 MM		$8,100 MM	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Diagnostics Continued						
Independent Labs	$25 Copay After Deductible	OON Deductible & Coinsurance	$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	$100 Copay After Deductible	OON Deductible & Coinsurance
Outpatient Facility *- Pre-certification Required*						
Outpatient Surgical Facility Services	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Chemotherapy & Radiotherapy *30 Days/Plan Year*	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Infusion/Injection	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Labs *No Pre-certification Required*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Dialysis *Limited to acute temporary dialysis*	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Inpatient Services *- Pre-certification Required within 48 hours, if admitted*						
Inpatient Hospital Care Facility	20% After Deductible	OON Deductible & Coinsurance	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	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility *30 Days/Plan Year*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Rehabilitation Facility *30 Days/Plan Year*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Inpatient Hospice *30 Days/Plan Year*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

COVERED SERVICES

SERVICE	$2,500 MM		$5,300 MM		$8,100 MM	
	INN	*OON*	*INN*	*OON*	*INN*	*OON*
Preventative Services						
Preventative Care *Including but Not Limited to: Annual Wellness Exams, Labs, Immunizations*	$0 Copay $0 Deductible	OON Deductible & Coinsurance	$0 Copay $0 Deductible	OON Deductible & Coinsurance	$0 Copay $0 Deductible	OON Deductible & Coinsurance
Maternity Services						
Prenatal / Postnatal Office Visit / Delivery	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Room and Board	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services						
Durable Medical Equipment (DME) *Pre-certification Required* *Limited to 12-month rental or purchase price, whichever is less*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Home Health Care Visits *Pre-certification Required* *30 Visits/Plan Year*	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Allergy Testing / Injections *Pre-certification Required* *1 Visit/Plan Year*	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Diabetic Nutritional Counseling	$0 Copay	OON Deductible & Coinsurance	$0 Copay	OON Deductible & Coinsurance	$0 Copay	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

MM FORMULARY

RETAIL PHARMACY

30 Day Supply at Retail, the Mail Order Required - See Formulary

	INN	*OON*
Preventive	$0 Copay	OON Deductible & Coinsurance
Generic *30 Day Supply at Retail for Urgent Care Drugs.* *30 Day Supply Maintenance Medication at Retail.*	$10 Copay	OON Deductible & Coinsurance
Preferred Brand Name *30 Day Supply at Retail for Urgent Care Drugs.* *30 Day Supply Maintenance Medication at Retail.*	$90 Copay	OON Deductible & Coinsurance
Non-Preferred Brand Name *30 Day Supply at Retail for Urgent Care Drugs.* *30 Day Supply Maintenance Medication at Retail.*	$110 Copay	OON Deductible & Coinsurance
GLP-1 Medication ****See GLP-1 Receptor Agonist Coverage Rider***	Brand Name: $550 Copay Compounded: $200 Copay	OON Deductible & Coinsurance
Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available

PRESCRIPTION DRUGS

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

MAIL ORDER / RETAIL PHARMACY

	INN	*OON*
Preventive	$0 Copay	OON Deductible & Coinsurance
Generic *90 Day Supply*	$20 Copay	OON Deductible & Coinsurance
Preferred Brand Name *90 Day Supply*	$180 Copay	OON Deductible & Coinsurance
Non-Preferred Brand Name *90 Day Supply*	$220 Copay	OON Deductible & Coinsurance
GLP-1 Medication ***See GLP-1 Receptor Agonist Coverage Rider. Qualifying member, not covered for weight loss.**	Brand Name: $500 Copay Compounded: $200 Copay	OON Deductible & Coinsurance
Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans 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
- **In-Network Provider**: Providers within the network shown on your ID Card. Always confirm status before scheduling care.

GLP-1 Receptor Agonist Coverage Rider

The Plan covers GLP-1 receptor agonist medications — including but not limited to semaglutide, tirzepatide, and liraglutide, and other formulations approved by the Plan's Pharmacy & Therapeutics guidelines — when prescribed by a licensed provider for an indication supported by the Plan's formulary criteria and/or medical necessity documentation.

Member Cost-Sharing

Members are responsible for the following copayment amounts per fill, up to the supply limit stated below, when obtained through an in-network pharmacy:

Product Type	Member Copay (Per Fill)
Brand-Name GLP-1 Medication *FDA-approved, manufactured product*	**$550**
Compounded GLP-1 Medication *Elected by Member as an alternative to the brand-name product*	**$200**

Supply limit: up to a [30 / 90]-day supply per fill. Copays listed above apply to in-network pharmacy fills only; out-of-network fills are subject to the Plan's standard out-of-network prescription drug provisions. These copay amounts apply regardless of the Plan's general formulary tier structure and supersede any conflicting standard prescription drug copay schedule with respect to GLP-1 receptor agonist products specifically.

Conditions of Coverage for Compounded GLP-1 Alternatives

Compounded GLP-1 Coverage ($200 Tier) — Conditions

To qualify for the $200 cost-share tier, a compounded GLP-1 medication must meet all of the following:

1. ***Pharmacy source.*** *The medication must be dispensed by a state-licensed 503A compounding pharmacy or 503B outsourcing facility that is in good standing.*
2. ***Regulatory status.*** *Coverage depends on current FDA guidance and the drug shortage status of the active ingredient(s) used. If compounding that ingredient is no longer legally permitted, the Plan may modify, limit, or end this coverage tier.*
3. ***Member acknowledgment.*** *The Member must sign a Plan-approved form confirming they understand the compounded product is not FDA-approved and has not been evaluated by the FDA for safety or effectiveness.*
4. ***Prior authorization.*** *Prior authorization may be required to confirm the treatment is clinically appropriate and to document that the Member is choosing the compounded alternative instead of the brand-name product.*
5. ***Matching indication.*** *The compounded product must be prescribed for the same indication that would otherwise qualify the brand-name GLP-1 product for coverage under this Rider.*

This is just a brief overview of this rider, please see your full plan document for all details.

MONTHLY PREMIUMS BY AGE

		$2,500	$5,300	$8,100
Ages 18-29	Employee	$689.00	$614.00	$514.00
	Employee + Spouse	$1,219.00	$1,089.00	$909.00
	Employee + Child(ren)	$1,189.00	$984.00	$834.00
	Family	$1,679.00	$1,479.00	$1,199.00
Ages 30-44	Employee	$719.00	$634.00	$534.00
	Employee + Spouse	$1,269.00	$1,119.00	$939.00
	Employee + Child(ren)	$1,249.00	$1,024.00	$864.00
	Family	$1,749.00	$1,539.00	$1,249.00
Ages 45-54	Employee	$759.00	$654.00	$564.00
	Employee + Spouse	$1,319.00	$1,179.00	$989.00
	Employee + Child(ren)	$1,279.00	$1,064.00	$884.00
	Family	$1,819.00	$1,599.00	$1,299.00
Ages 55-64	Employee	$839.00	$684.00	$604.00
	Employee + Spouse	$1,489.00	$1,269.00	$1,049.00
	Employee + Child(ren)	$1,359.00	$1,134.00	$964.00
	Family	$2,099.00	$1,729.00	$1,399.00

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