SUMMARY OF BENEFITS & COVERAGE

VL

VISIT LIMIT PLAN

PHCS

NETWORK

PPO

INN & OON BENEFITS

VL Plan Comparison

Rates Effective As of September 1, 2026

PLAN AT A GLANCE	*INN*
Individual Deductible	$1,500 - $3,500
Family Deductible	$3,000 - $7,000
Individual Out-of-Pocket Max	$10,600
Family Out-of-Pocket Max	$21,200

***Out-of-Pocket Maximum for Member Accumulated Deductible and Copays*
***For Services Beyond Plan Visit Limits*

Bright Life Health & Wellness

COVERED SERVICES

SERVICE	$1,500 VL	$2,500 VL	$3,500 VL
	INN	*INN*	*INN*
Office & Outpatient			
Physician Office Visits (PCP & Specialist) *10 Visits/Benefit Period Maximum. Combined for PCP, Specialist, and Urgent Care Office Visits.*			
Primary Care Physician	$50 Copay Before Deductible	$50 Copay Before Deductible	$50 Copay Before Deductible
Specialist Office Visit *No Referral Needed*	$50 Copay Before Deductible	$50 Copay Before Deductible	$50 Copay Before Deductible
Urgent Care Office Visit	$50 Copay Before Deductible	$50 Copay Before Deductible	$50 Copay Before Deductible
Chiropractic Care *12 Visits/Calendar Year Maximum*	$50 Copay Before Deductible	$50 Copay Before Deductible	$50 Copay Before Deductible
Surgery Performed In Office	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery
Therapies *16 Visits/ Calendar Year Combined - Physical, Occupational, Speech, ABA, Cardiac & Respiratory*	$100 Copay/Visit After Deductible	$100 Copay/Visit After Deductible	$100 Copay/Visit 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	$0 Copay Unlimited Visits	$0 Copay Unlimited Visits
Labs *In Office/Independent (3/Benefit Plan Year)* *Outpatient (3/Benefit Plan Year)*	$35 Copay Before Deductible	$35 Copay Before Deductible	$35 Copay Before Deductible
X-Rays *3/Benefit Plan Year*	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Diagnostic Testing / Advanced Imaging *Pre-certification Required* *3/Benefit Plan Year*	$350 Copay After Deductible	$350 Copay After Deductible	$350 Copay After Deductible
Emergency & Ambulance *- Pre-certification Required within 48 hours, if admitted*			
Emergency Room Care *See Notes* *2 Visit Limit/Benefit Period for Accident-Related Visits* *2 Visit Limit/Benefit Period for Sickness-Related Visits*	$750 Copay After Deductible	$750 Copay After Deductible	$750 Copay After Deductible

Bright Life Health & Wellness

COVERED SERVICES

SERVICE	$1,500 VL	$2,500 VL	$3,500 VL
	INN	*INN*	*INN*
Emergency & Ambulance Continued			
Observation Room Hospital	$750 Copay After Deductible	$750 Copay After Deductible	$750 Copay After Deductible
Ambulance *Land* *Air* ***2 Per Person per Benefit Plan Year Combined*	$250 Copay After Deductible $1,000 Copay After Deductible	$250 Copay After Deductible $1,000 Copay After Deductible	$250 Copay After Deductible $1,000 Copay After Deductible
Inpatient Hospital Services *- Pre-certification Required*			
Inpatient Hospital Care Facility *Stays Limited to:* *10 Days/Admission (ICU & Non-ICU)* *3 Hospitalizations/Benefit Period*	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission After Deductible
Inpatient Surgical Services *2 Surgeries/Plan Year*	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery After Deductible
Inpatient Skilled Nursing Facility *10-Day Limit/Benefit Year*	$150 Copay/Day After Deductible	$150 Copay/Day After Deductible	$150 Copay/Day After Deductible
Inpatient Rehabilitation Facility *10-Day Limit/Benefit Year*	$150 Copay/Day After Deductible	$150 Copay/Day After Deductible	$150 Copay/Day After Deductible
Organ Transplant	Not Covered	Not Covered	Not Covered
Hospice *30 Day Limit Per Lifetime*	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible
Associated/Incidental Inpatient Services *Anesthesia, Pathology, Physician Services, and Any Other Incurred Services*	$250 Copay/Service After Deductible	$250 Copay/Service After Deductible	$250 Copay/Service After Deductible
Outpatient Services *- Pre-certification Required*			
Outpatient Surgical Services *Outpatient Hospital, Surgery Center, or Office* *3 Surgeries/Plan Year*	$250 Copay/Surgery After Deductible	$250 Copay/Surgery After Deductible	$250 Copay/Surgery After Deductible

COVERED SERVICES

SERVICE	$1,500 VL	$2,500 VL	$3,500 VL
	INN	*INN*	*INN*
Outpatient Services Continued *- Pre-certification Required*			
Surgery Services *Surgeon, Anesthesia, and Any Other Incurred Services Associated with Outpatient Surgery*	$500 Copay/Service After Deductible	$500 Copay/Service After Deductible	$500 Copay/Service After Deductible
Outpatient Chemotherapy & Radiotherapy *10 Visit Limit/Plan Year* *Maximum Combined with Infusion/Injection Drugs*	$350 Copay/Visit After Deductible	$350 Copay/Visit After Deductible	$350 Copay/Visit After Deductible
Infusion / Injection *10 Visit Limit/Benefit Year* *Maximum Combined with Chemotherapy / Radiation*	$350 Copay/Visit After Deductible	$350 Copay/Visit After Deductible	$350 Copay/Visit After Deductible
Dialysis	Not Covered	Not Covered	Not Covered
Preventative Services			
Preventative Care *Including but Not Limited to: Annual Wellness Exams, Labs, Immunizations. See Preventative Care Guide*	$0 Copay $0 Deductible	$0 Copay $0 Deductible	$0 Copay $0 Deductible
Maternity Services *- Charges Outside of Hospital Delivery*			
Pregnancy, Maternity *Including all Routine Maternity Services Such as Office Visits, Lab Work, Radiology, Prenatal/Postnatal Care, etc.* *Excluded Genetic Testing Unless Medically Necessary*	$500 Copay After Deductible	$500 Copay After Deductible	$500 Copay After Deductible
Other Covered Services			
Durable Medical Equipment (DME) *Pre-certification Required* *Copayment is Applied Per Item Received. 5 Items/Benefit Period.*	$250 Copay/Item After Deductible	$250 Copay/Item After Deductible	$250 Copay/Item After Deductible

COVERED SERVICES

SERVICE	$1,500 VL	$2,500 VL	$3,500 VL
	INN	*INN*	*INN*
Other Covered Services Continued			
Home Health Care Visits *Pre-certification Required* *10 Visits/Plan Year*	$50 Copay/Visit After Deductible	$50 Copay/Visit After Deductible	$50 Copay/Visit After Deductible
Nutritional Counseling *1 Visit/Plan Year*	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible
Prosthetics *Pre-certification Required* *1 Item/Benefit Plan Year*	$500 Copay/Item After Deductible	$500 Copay/Item After Deductible	$500 Copay/Item After Deductible
Allergies *Shots/Serums: 24 Visits/Plan Year* *Visits/Testing: 2 Visits/Plan Year*	$50 Copay After Deductible $50 Copay/Visit After Deductible	$50 Copay After Deductible $50 Copay/Visit After Deductible	$50 Copay After Deductible $50 Copay/Visit 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.

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

VL FORMULARY

RETAIL PHARMACY

- See Formulary

	INN
Preventive Medicine Rx *Generic or Brand (See Formulary)*	$0 Copay
Generic Drugs - Urgent Care Rx *30 Day-Supply at Retail Pharmacies. (See Formulary)*	$0 Copay
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
Preferred Brand Name	PAP Available
Non-Preferred Brand Name	PAP Available
Specialty Drugs	PAP Available

PRESCRIPTION DRUGS

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

MAIL ORDER / RETAIL PHARMACY

	INN
Generic Drugs *90 Day Supply Maintenance Medication. (See Formulary)*	$0 Copay
Preferred Brand Name	PAP Available
Non-Preferred Brand Name	PAP Available
Specialty Drugs	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
- **In-Network Provider**: Providers within the network shown on your ID Card. Always confirm status before scheduling care.

MONTHLY PREMIUMS BY AGE

		$1,500	*$2,500*	*$3,500*
Ages **18-29**	**Employee**	$314.00	$309.00	$299.00
	Employee + Spouse	$579.00	$554.00	$534.00
	Employee + Child(ren)	$569.00	$539.00	$519.00
	Family	$839.00	$819.00	$799.00
Ages **30-44**	**Employee**	$319.00	$319.00	$309.00
	Employee + Spouse	$634.00	$614.00	$594.00
	Employee + Child(ren)	$619.00	$599.00	$579.00
	Family	$899.00	$879.00	$859.00
Ages **45-54**	**Employee**	$359.00	$369.00	$349.00
	Employee + Spouse	$704.00	$684.00	$664.00
	Employee + Child(ren)	$689.00	$669.00	$649.00
	Family	$969.00	$949.00	$929.00
Ages **55-64**	**Employee**	$389.00	$379.00	$369.00
	Employee + Spouse	$754.00	$734.00	$714.00
	Employee + Child(ren)	$739.00	$719.00	$699.00
	Family	$999.00	$979.00	$959.00

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