



# Summary of Benefits & Coverage

**VL \$250/\$500 Deductible**

Rates effective as of January 1, 2025  
PPO in-network

Network Options:  
PHCS PPO or BCBS PPO (Not Currently Available)

\*\*This plan is underwritten by Benefit Logistics Captive Insurance Co, Inc NAIC # 17633 and not by PHCS, or any BCBS Licensee.

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NETWORK		INN
Payment for Services		
In-network Provider: The provider network is shown on your I.D. card. For help in locating in-network providers, <a href="#">click here</a> .		
Maximum Annual Benefit	See Services Performed	
Deductible (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>	\$250 \$500	
Out-of-Pocket Maximum (For member accumulated deductible and copays (Individual/Family)  Out of Pocket – Maximum for services beyond the plan visit limits	\$9,200 \$18,400 Unlimited	
Copays: Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.		
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)		
<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>
Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<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><li>Organ Transplant Services</li></ul>	
Services may require preauthorization. Failure to obtain preauthorization will result in denial of benefits.		
Precertification 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.  Emergencies are covered but do require authorization/certification within 48 hours.		
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> 10 visits per benefit year maximum is combined for PCP office visits, Specialist Office visits, and Urgent Care visits. 12 visits per benefit year maximum for Chiropractic Care. <ul style="list-style-type: none"> <li>• Primary Care Physician</li> <li>• Specialist Office Visit</li> <li>• Urgent Care Visit</li> <li>• Spinal Manipulation Chiropractic</li> <li>• Surgery Performed in the Office (See Outpatient Surgery)</li> </ul>	\$50 Copay After Deductible
<b>Telemedicine-</b> through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>• Emergency Room Care               <ul style="list-style-type: none"> <li>◦ 2-visit limit per benefit year for accident-related visits</li> <li>◦ 2-visit limit per benefit year for sickness-related visits</li> </ul> </li> <li>• Emergency Medical Transportation               <ul style="list-style-type: none"> <li>◦ Ground/Air Ambulance: 2 per benefit year</li> </ul> </li> </ul> Please note that for a true medical emergency, any provider may be used.	\$250 Copay After Deductible
<b>Diagnostic Testing/Imaging</b> (Precertification Required) 3 per benefit year	\$200 Copay After Deductible
<b>Labs</b> (3 per Benefit Plan Year)	\$25 Copay
<b>X-rays</b> (3 per Benefit Plan Year)	\$50 Copay
<b>Outpatient Facility Services</b> (Precertification Required) <ul style="list-style-type: none"> <li>• Infusions/Injections               <ul style="list-style-type: none"> <li>◦ 10-visit limit per benefit year; maximum combined with chemotherapy/radiation</li> </ul> </li> <li>• Surgical Services (Outpatient hospital, Surgery Center of Office)               <ul style="list-style-type: none"> <li>◦ 3 surgeries per benefit year (includes surgeon, anesthesia and any other incurred services associated with outpatient surgery)</li> </ul> </li> <li>• Outpatient Chemotherapy and Radiotherapy               <ul style="list-style-type: none"> <li>◦ 10-visit limit per benefit year; maximum combined with infusion/injection drugs</li> </ul> </li> <li>• Dialysis</li> </ul>	\$100 Copay/Visit After Deductible  \$250 Copay/Service After Deductible  \$100 Copay/Visit After Deductible  Not Covered
<b>Inpatient Services</b> (Precertification Required) Stays Limited To: 2 ICU hospitalizations per benefit period and 2 Non-ICU hospitalizations per benefit period. (10-day limit per ICU hospitalization, 10-day limit per Non-ICU hospitalization)  Associated/Incidental Inpatient Services (Included Anesthesia, Pathology, Physician Services, and any other incurred services)	\$1,000 Copay/Admission After Deductible  \$250 Copay/Service After Deductible

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NETWORK	INN
<b>Inpatient Services</b> (Precertification Required) Inpatient Hospital Surgical Services, All Fees 2 surgeries per plan year  Inpatient Rehabilitation Facility 10-day limit per benefit year	\$1,000 Copay/Surgery After Deductible  \$50 Copay/Day After Deductible
<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
<b>Other Covered Services</b>	
<b>Therapy</b> 16 visits per benefit year maximum combined <ul style="list-style-type: none"> <li>Physical &amp; Occupational Therapies</li> <li>Speech Therapy</li> <li>Cardiac Rehabilitation Therapy</li> </ul>	\$50 Copay After Deductible
<b>Pregnancy/Maternity</b> <ul style="list-style-type: none"> <li>Routine Vaginal Delivery</li> <li>Routine C-section Delivery</li> <li>All Other Maternity Service (Other maternity services included: office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded: Genetic testing, unless medically necessary.)</li> </ul>	\$250 Copay After Deductible \$500 Copay After Deductible 100% Covered
<b>Home Health Care</b> (Precertification Required) 10-day limit per benefit year	\$50 Copay After Deductible
<b>Hospice Care</b> 30-day limit per lifetime	\$0 Copay After Deductible
<b>Inpatient Skilled Nursing Facility</b> (Precertification Required) 10-day visit limit per benefit year	\$50 Copay/Day After Deductible
<b>Durable Medical Equipment (DME)</b> (Precertification Required) Copayment is applied per item received. 5 items/benefit period.	\$50 Copay/Item After Deductible
<b>Prosthetics</b> (Precertification Required) 1 item per benefit year	\$50 Copay/Item After Deductible
<b>Organ Transplant</b>	Not Covered

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NETWORK		INN
<b>Diabetic Nutritional Counseling</b> 1 visit per benefit year		\$0 Copay After Deductible
<b>Allergies</b> <ul style="list-style-type: none"><li>Shots (24 visits per benefit year)</li><li>Visits/Testing (2 visits per benefit year)</li></ul>		\$25 Copay After Deductible \$50 Copay After Deductible
Prescription Drugs		
<b>Retail Pharmacy Copayments</b>  30-day supply at retail pharmacies  Mail order required for maintenance medication after initial 30-day supply	<b>Generic</b> Maintenance Rx	\$0 Copay
	<b>Generic</b> Urgently Needed Care Rx	\$0 Copay
	<b>Preferred Brand Name Drugs</b>	Patient Assistance Plans Available
	<b>Non-Preferred Brand Name Drugs</b>	Patient Assistance Plans Available
<b>Mail Order or Retail Pharmacy Copayments</b>  90-day supply	<b>Generic</b>	\$0 Copay
	<b>Preferred Brand Name Drugs</b>	Patient Assistance Plans Available
	<b>Non-Preferred Brand Name Drugs</b>	Patient Assistance Plans Available
RX Benefit Highlights		
<b>Rx Company</b>		ProAct
<b>Phone 24/7/365</b>		1-877-635-9545
<b>Website</b>		<a href="https://secure.proactrx.com/">https://secure.proactrx.com/</a>
<b>Formulary</b>		<a href="https://bit.ly/4j9crFR">https://bit.ly/4j9crFR</a>
<b>Mail Order/TeleHealth</b>		<a href="https://bit.ly/4j9crFR">https://bit.ly/4j9crFR</a>

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PREMIUMS BY AGE BAND		
NETWORK	PHCS	BCBS (Not Currently Available)
AGES 18-29		
Employee	\$339.00	\$419.00
Employee + Spouse	\$659.00	\$759.00
Employee + Child(ren)	\$679.00	\$779.00
Family	\$929.00	\$1,049.00
AGES 30-44		
Employee	\$409.00	\$489.00
Employee + Spouse	\$729.00	\$829.00
Employee + Child(ren)	\$709.00	\$809.00
Family	\$969.00	\$1,089.00
AGES 45-54		
Employee	\$439.00	\$519.00
Employee + Spouse	\$739.00	\$839.00
Employee + Child(ren)	\$729.00	\$829.00
Family	\$1,019.00	\$1,139.00
AGES 55-64		
Employee	\$489.00	\$569.00
Employee + Spouse	\$759.00	\$859.00
Employee + Child(ren)	\$739.00	\$839.00
Family	\$1,049.00	\$1,169.00