



# PLAN COMPARISON:

## Summary of Benefits & Coverage

Rates effective as of January 1, 2026

Network Options: CIGNA EPO (In-Network)

EPO \$500/\$1,000 MM Deductible

EPO \$750/\$1,500 MM Deductible

EPO \$1,000/\$2,000 MM Deductible

EPO \$1,500/\$3,000 MM Deductible



FORMAL APPAREL HEALTHCARE ASSOCIATION

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\*This plan is underwritten by Benefit Logistic Captive Insurance Co, Inc NAIC #17633 and not by Cigna.

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PLAN	EPO \$500	EPO \$750	EPO \$1,000	EPO \$1,500
<b>In-network Provider:</b> The provider network is shown on your I.D. card. For help locating in-network providers, <a href="#">click here</a> .				
<b>Deductible</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$500 \$1,000	\$750 \$1,500	\$1,000 \$2,000	\$1,500 \$3,000
<b>Out of Pocket Maximum - Including Deductible</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$9,200 \$18,400	\$9,200 \$18,400	\$9,200 \$18,400	\$9,200 \$18,400
<b>PCP Office Visit</b>	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
<b>Specialist Office Visit</b> (No Referral Needed)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
<b>Urgent Care Office Visit</b>	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
<b>Surgery Performed in the Office</b>	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery	See Outpatient Surgery
<b>Chiropractic Care</b> 12 visits per calendar year maximum	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)
<b>Therapies:</b> Physical, Speech, Occupational, Cardiac, & Resp 16 Visits per calendar year maximum combined	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)	\$50 Copay/Visit (After Deductible)
<b>Labs</b>	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
<b>X-rays</b>	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay
<b>Diagnostic Testing/Advanced Imaging</b> (Pre-Certification Required)	\$200 Copay	\$200 Copay	\$200 Copay	\$200 Copay
<b>Telemedicine through OurLiveDoc ONLY</b> <b>Primary and Urgent Care, Behavioral Health</b> Call 940-LIVE-DOC (940-548-3362) to get started	\$0 Copay Unlimited Visits	\$0 Copay Unlimited Visits	\$0 Copay Unlimited Visits	\$0 Copay Unlimited Visits
<b>Emergency Services</b> (Pre-certification is required within 48 hours of admission, if admitted)				
<b>Emergency Room Care</b> Please note that for a true medical emergency, any provider may be used.	\$1,000 Copay (After Deductible)	\$1,000 Copay (After Deductible)	\$1,000 Copay (After Deductible)	\$1,000 Copay (After Deductible)

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PLAN	EPO \$500	EPO \$750	EPO \$1,000	EPO \$1,500
<b>Ambulance</b>	\$250 Copay (After Deductible)			
<b>Inpatient or Partial Hospitalization Services (Pre-certification Required)</b>				
<b>Inpatient Hospital Care Facility or Partial Hospitalization</b>	\$2,500 Copay/Admission (After Deductible)			
<b>Inpatient Surgical Services</b>	\$2,500 Copay/Surgery (After Deductible)			
<b>Associated/Incidental Inpatient Services</b> (Includes Anesthesia, Pathology, Physician Services, and any other incurred services)	\$250 Copay/Surgery (After Deductible)			
<b>Inpatient Skilled Nursing Facility</b>	\$50 Copay/Day (After Deductible)			
<b>Inpatient Rehabilitation Facility</b>	\$50 Copay/Day (After Deductible)			
<b>Hospice</b> 30-day limit per Lifetime	\$0 Copay (After Deductible)			
<b>Organ Transplant</b>	\$2,500 Copay/Admission (After Deductible)			
<b>Outpatient Services (Pre-certification Required)</b>				
<b>Outpatient Surgical Services (Outpatient Hospital, Surgery Center, or Office)</b>	\$2,500 Copay/Surgery (After Deductible)			
<b>Surgery Services</b> (Includes surgeon, anesthesia, and any other incurred services associated with outpatient surgery)	\$250 Copay/Service (After Deductible)			
<b>Outpatient Chemotherapy and Radiotherapy</b>	\$250 Copay/Visit (After Deductible)			
<b>Infusion / Injection</b>	\$250 Copay/Visit (After Deductible)			

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PLAN	EPO \$500	EPO \$750	EPO \$1,000	EPO \$1,500
<b>Dialysis</b>	\$250 Copay (After Deductible)			
<b>Outpatient Labs</b> (No Pre-certification Required)	\$100 Copay (After Deductible)			
<b>Preventive Service</b>				
<b>Preventive Care</b> including but not limited to: Annual Wellness Exams, Labs and Immunizations See Preventative Care Guide	\$0 Copay \$0 Deductible	\$0 Copay \$0 Deductible	\$0 Copay \$0 Deductible	\$0 Copay \$0 Deductible
<b>Maternity Services</b>				
<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 including office visits, lab work, radiology, prenatal/postnatal care etc. Excluded Genetic testing unless medically necessary)</li> </ul>	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)
	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)	\$2,500 Copay/Admission (After Deductible)
	100% Covered	100% Covered	100% Covered	100% Covered
<b>Other Covered Services</b>	Participating Provider	Participating Provider	Participating Provider	Participating Provider
<b>Home Health Care Visits</b> (Pre-certification Required) 10 visits per Benefit Year	\$50 Copay/Visit (After Deductible)			
<b>Durable Medical Equipment (DME)</b> (Pre-certification Required) Copayment is applied per item received. 5 items/benefit period.	\$50 Copay/Item (After Deductible)			
<b>Diabetic Nutritional Counseling</b> (1 visit per Plan Year)	\$0 Copay (After Deductible)			
<b>Prosthetics</b> (Pre-certification Required) (1 item per Benefit Plan Year)	\$50 Copay/Item (After Deductible)			
<b>Allergies</b> <ul style="list-style-type: none"> <li>Shots</li> <li>Visits/Testing</li> </ul>	\$25 Copay (After Deductible)			
	\$50 Copay/Visit (After Deductible)			

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PLAN		EPO \$500	EPO \$750	EPO \$1,000	EPO \$1,500
<b>Prescription Drugs</b>					
<b>Retail Pharmacy Copayments</b> 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	<b>Preventive Medicine Rx - Generic or Brand</b> (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	<b>Generic Drugs - Urgent Care Rx</b> (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	<b>Generic Drugs - Maintenance Rx</b> (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	<b>Preferred Brand Name Drugs</b>	PAP Available	PAP Available	PAP Available	PAP Available
	<b>Non-Preferred Brand Name Drugs</b>	PAP Available	PAP Available	PAP Available	PAP Available
	<b>Specialty Drugs</b>	PAP Available	PAP Available	PAP Available	PAP Available
<b>Mail Order or Retail Pharmacy Copayments</b> 90-day supply maintenance medication	<b>Generic Drugs</b> (See Formulary)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
	<b>Preferred Brand Name Drugs</b>	Patient Assistance Plans Available			
	<b>Non-Preferred Brand Name Drugs</b>	Patient Assistance Plans Available			
	<b>Specialty Drugs</b>	Patient Assistance Plans Available			
<b>Rx Benefit Highlights</b>					
<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>				

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.

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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PREMIUMS BY AGE BAND				
PLAN	EPO \$500	EPO \$750	EPO \$1,000	EPO \$1,500
<b>AGES 18-29</b>				
Employee	\$429.00	\$409.00	\$389.00	\$369.00
Employee + Spouse	\$789.00	\$769.00	\$749.00	\$729.00
Employee + Child(ren)	\$779.00	\$759.00	\$739.00	\$719.00
Family	\$1,059.00	\$1,039.00	\$1,019.00	\$999.00
<b>Ages 30-44</b>				
Employee	\$489.00	\$469.00	\$449.00	\$419.00
Employee + Spouse	\$829.00	\$799.00	\$779.00	\$759.00
Employee + Child(ren)	\$819.00	\$789.00	\$769.00	\$743.00
Family	\$1,119.00	\$1,089.00	\$1,059.00	\$1,039.00
<b>Ages 45-54</b>				
Employee	\$519.00	\$499.00	\$479.00	\$459.00
Employee + Spouse	\$869.00	\$839.00	\$819.00	\$809.00
Employee + Child(ren)	\$859.00	\$829.00	\$809.00	\$789.00
Family	\$1,169.00	\$1,149.00	\$1,129.00	\$1,109.00
<b>Ages 55-64</b>				
Employee	\$569.00	\$549.00	\$529.00	\$509.00
Employee + Spouse	\$889.00	\$869.00	\$849.00	\$839.00
Employee + Child(ren)	\$869.00	\$849.00	\$839.00	\$799.00
Family	\$1,209.00	\$1,169.00	\$1,149.00	\$1,129.00

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