PLAN COMPARISON:
Summary of Benefits & Coverage

LIFEX RESEARCH CORP

Rates effective as of January 1, 2026
Network Options: First Health PPO

$500/$1,000 Deductible
$750/$1,500 Deductible
$1,000/$2,000 Deductible
$1,500/$3,000 Deductible

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PLAN	$500	OON What Member Pays	$750	OON What Member Pays	$1,000	OON What Member Pays	$1,500	OON What Member Pays
In-network Provider: The provider network is shown on your I.D. card. For help locating in-network providers, click here.								
Deductible • Individual • Family	$500 $1,000	$500 $1,000	$750 $1,500	$750 $1,500	$1,000 $2,000	$1,000 $2,000	$1,500 $3,000	$1,500 $3,000
Out of Pocket Maximum - Including Deductible • Individual • Family	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400	$9,200 $18,400
PCP Office Visit	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible
Specialist Office Visit (No Referral Needed)	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible
Urgent Care Office Visit	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible
Surgery Performed in the Office	See Outpatient Surgery	Copay + 10% After Deductible	See Outpatient Surgery	Copay + 10% After Deductible	See Outpatient Surgery	Copay + 10% After Deductible	See Outpatient Surgery	Copay + 10% After Deductible
Chiropractic Care 12 visits per calendar year maximum	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible
Therapies: Physical, Speech, Occupational, Cardiac, & Resp 16 Visits per calendar year maximum combined	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Labs (Independent Lab Only)	$25 Copay (After Deductible)	Copay + 10% After Deductible	$25 Copay (After Deductible)	Copay + 10% After Deductible	$25 Copay (After Deductible)	Copay + 10% After Deductible	$25 Copay (After Deductible)	Copay + 10% After Deductible
X-Rays (Stand Alone Radiology Only)	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible	$50 Copay (After Deductible)	Copay + 10% After Deductible
Diagnostic Testing/Advanced Imaging (Pre-Certification Required)	$200 Copay After Deductible	Copay + 10% After Deductible	$200 Copay After Deductible	Copay + 10% After Deductible	$200 Copay After Deductible	Copay + 10% After Deductible	$200 Copay After Deductible	Copay + 10% After Deductible
Telemedicine through OurLiveDoc ONLY **Primary and Urgent Care, Behavioral Health** Call 940-LIVE-DOC (940-548-3362) to get started	$0 Copay Unlimited Visits	Copay + 10% After Deductible	$0 Copay Unlimited Visits	Copay + 10% After Deductible	$0 Copay Unlimited Visits	Copay + 10% After Deductible	$0 Copay Unlimited Visits	Copay + 10% After Deductible
Emergency Services (Pre-certification is required within 48 hours of admission, if admitted)								
Emergency Room Care Please note that for a true medical emergency, any provider may be used.	$1,000 Copay (After Deductible)	Copay + 10% After Deductible	$1,000 Copay (After Deductible)	Copay + 10% After Deductible	$1,000 Copay (After Deductible)	Copay + 10% After Deductible	$1,000 Copay (After Deductible)	Copay + 10% After Deductible

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Ambulance - Land **Ambulance** - Air (2 per Benefit Plan Year Combined)	$250 Copay (After Deductible) $1,000 Copay (After Deductible)	Copay + 10% After Deductible	$250 Copay (After Deductible) $1,000 Copay (After Deductible)	Copay + 10% After Deductible	$250 Copay (After Deductible) $1,000 Copay (After Deductible)	Copay + 10% After Deductible	$250 Copay (After Deductible) $1,000 Copay (After Deductible)	Copay + 10% After Deductible
Inpatient or Partial Hospitalization Services (Pre-certification Required)								
Inpatient Hospital Care Facility or **Partial Hospitalization**	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible
Inpatient Surgical Services	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
Associated/Incidental Inpatient Services (Includes Anethesia, Pathology, Physician Services, and any other incurred services)	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible	$250 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$250 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$250 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
Inpatient Skilled Nursing Facility	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible
Inpatient Rehabilitation Facility	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible
Hospice 30-day limit per Lifetime	$0 Copay (After Deductible)	Copay + 10% After Deductible	$0 Copay (After Deductible)	Copay + 10% After Deductible	$0 Copay (After Deductible)	Copay + 10% After Deductible	$0 Copay (After Deductible)	Copay + 10% After Deductible
Organ Transplant	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible
Outpatient Services (Pre-certification Required)								
Outpatient Surgical Services (Outpatient Hospital, Surgery Center, or Office)	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
Surgery Services (Includes surgeon, anesthesia, and any other incurred services associated with outpatient surgery)	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible
Outpatient Chemotherapy and Radiotherapy	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Infusion / Injection	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible

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Dialysis	$250 Copay (After Deductible)	Copay + 10% After Deductible	$250 Copay (After Deductible)	Copay + 10% After Deductible	$250 Copay (After Deductible)	Copay + 10% After Deductible	$250 Copay (After Deductible)	Copay + 10% After Deductible
Outpatient Labs (No Pre-certification Required)	$100 Copay (After Deductible)	Copay + 10% After Deductible	$100 Copay (After Deductible)	Copay + 10% After Deductible	$100 Copay (After Deductible)	Copay + 10% After Deductible	$100 Copay (After Deductible)	Copay + 10% After Deductible
Preventive Service								
Preventive Care including but not limited to: Annual Wellness Exams, Labs and Immunizations See Preventative Care Guide	$0 Copay $0 Deductible	Copay + 10% After Deductible	$0 Copay $0 Deductible	Copay + 10% After Deductible	$0 Copay $0 Deductible	Copay + 10% After Deductible	$0 Copay $0 Deductible	Copay + 10% After Deductible
Maternity Services								
Pregnancy, Maternity • Routine Delivery (Vaginal or C-Section) • All other Routine Maternity Service (Including office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded Genetic testing unless medically necessary.)	$2,500 Copay/Admission (After Deductible) 100% Covered	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible) 100% Covered	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible) 100% Covered	Copay + 10% After Deductible	$2,500 Copay/Admission (After Deductible) 100% Covered	Copay + 10% After Deductible
Other Covered Services								
Home Health Care Visits (Pre-certification Required) 10 visits per Benefit Year	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Durable Medical Equipment (DME) (Pre-certification Required) Copayment is applied per item received. 5 items/benefit period.	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible
Diabetic Nutritional Counseling (1 visit per Plan Year)	$0 Copay (After Deductible)	Copay + 10% After Deductible	$0 Copay (After Deductible)	Copay + 10% After Deductible	$0 Copay (After Deductible)	Copay + 10% After Deductible	$0 Copay (After Deductible)	Copay + 10% After Deductible
Prosthetics (Pre-certification Required) (1 item per Benefit Plan Year)	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible
Allergies • Shots/Serum • Visits/Testing	$25 Copay (After Deductible) $50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$25 Copay (After Deductible) $50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$25 Copay (After Deductible) $50 Copay/Visit (After Deductible)	Copay + 10% After Deductible	$25 Copay (After Deductible) $50 Copay/Visit (After Deductible)	Copay + 10% After Deductible

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Prescription Drugs									
Retail Pharmacy Copayments 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	**Preventive Medicine Rx - Generic or Brand** (See Formulary)	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible
	Generic Drugs - Urgent Care Rx (See Formulary)	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible
	Generic Drugs - Maintenance Rx (See Formulary)	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible
	Preferred Brand Name Drugs	PAP Available	Not Covered	PAP Available	Not Covered	PAP Available	Not Covered	PAP Available	Not Covered
	Non-Preferred Brand Name Drugs	PAP Available	Not Covered	PAP Available	Not Covered	PAP Available	Not Covered	PAP Available	Not Covered
	Specialty Drugs	PAP Available	Not Covered	PAP Available	Not Covered	PAP Available	Not Covered	PAP Available	Not Covered
Mail Order or Retail Pharmacy Copayments 90-day supply maintenance medication	**Generic Drugs** (See Formulary)	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible	$0 Copay	Copay + 10% After Deductible
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered
	Specialty Drugs	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered	Patient Assistance Plans Available	Not Covered
Rx Benefit Highlights									
Rx Company	ProAct								
Phone 24/7/365	1-877-635-9545								
Website	https://secure.proactrx.com/								
Formulary	Formulary								

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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