LIFEX RESEARCH CORP

Summary of Benefits & Coverage

MM $2,500 Deductible

Rates effective as of January 1, 2026
PPO in-network and out-of-network benefits

Network Options:
PHCS PPO

*This plan is underwritten by Benefit Re, Inc NAIC #17459 and not by any network.

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NETWORK	INN	OON
Payment for Services		
In-network Provider: The provider network is shown on your I.D. card. For help in locating in-network providers, click here.		
Maximum Annual Benefit	UNLIMITED	
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.)	20%	50%
Out-of-Pocket Limit (includes Deductible, Coinsurance, & Copayments) • Individual • Family	 $10,600 $21,200	 $20,300 $40,600
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.)		
• Annual Lab/X-Ray Tests • Annual Pap Smear/Mammogram • Cancer Screenings • Colonoscopies	• Diabetic Supply • Immunizations • Other Preventative Screenings • Precision Rx (Prescriptions)	• Telemedicine • Urgent Care and Office Visits • Well Baby Care • Wellness Visits
Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Children's Dental Check-Up • Children's Glasses	• Children's Eye Exam • Dialysis • Biofeedback	• Substance Abuse Services • Organ Transplant Services
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.		
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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Covered Services - Illness or Injury		

Physician Office Services
• Primary Care Physician
• Specialist Office Visit
  ◦ No referral needed
• Urgent Care Visit
• Chiropractic Care
  ◦ 24 visits per plan year
	$25 Copay
	$40 Copay
	$60 Copay
	$30 Copay
		OON Deductible & Coinsurance

Telemedicine- Through OurLiveDoc ONLY Primary and Urgent Care, Behavioral Health Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay Unlimited Visits	Not Covered
Emergency (Precertification is required within 48 hours of admission, if admitted)		
Emergency Room Care Precertification Required • Please note that for a true medical emergency, any provider may be used. • Emergency Ambulance Services ◦ Ground/Air Ambulance	20% After Deductible	OON Deductible & Coinsurance
Surgery Performed In Office	20% After Deductible	OON Deductible & Coinsurance
Labs	$25 Copay After Deductible	OON Deductible & Coinsurance
X-rays	$100 Copay After Deductible	OON Deductible & Coinsurance
Diagnostic Testing/Advanced Imaging (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
Outpatient Facility Services (Precertification Required) • Infusions/Injections • Outpatient Surgical Facility Services • Outpatient Chemotherapy and Radiotherapy (30 days per plan year) • Dialysis (limited to acute temporary dialysis)	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered
Inpatient Services (Precertification Required) • Inpatient Hospital Care Facility • Inpatient Hospital Surgical Services, All Fees • Intensive Care Unit (30 days per plan year) • Inpatient Rehabilitation Facility (30 days per plan year)	20% After Deductible	OON Deductible & Coinsurance

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Preventive Services - Click here for a complete list.		
Preventive Care/Screening/Immunization • Annual Adult Physical • Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria • Mammogram • Gynecological Services • Routine Colonoscopy • Well Child Care/Newborn Care	$0 Copay $0 Deductible	OON Deductible & Coinsurance
Other Covered Services		
Therapies 30 visits per plan year combined • Physical & Occupational Therapies • Speech Therapy • ABA & Respiratory	$40 Copay	OON Deductible & Coinsurance
Pregnancy/Maternity • Prenatal/Postnatal Office Visit • Room and Board	20% After Deductible	OON Deductible & Coinsurance
Home Health Care Visits (Precertification required) 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
Inpatient Hospice Care (Precertification required) 30 days per benefit year maximum • Residential/Facility	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility (Precertification required) 30-day visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (DME) (Precertification required) Limited to 12-month rental or purchase price, whichever is less	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant (Precertification required)	20% After Deductible	Not Covered
Allergy Testing/Injections	20% After Deductible	OON Deductible & Coinsurance

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Prescription Drugs			
Retail Pharmacy Copayments See Formulary 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	**Preventive Medicine**	$0 Copay	OON Deductible & Coinsurance
	Generic Urgently Needed Care Rx	$10 Copay	OON Deductible & Coinsurance
	Generic Maintenance Rx	$10 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Urgently Needed Care Rx	$90 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Maintenance Rx	$90 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Urgently Needed Care Rx	$110 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Maintenance Rx	$110 Copay	OON Deductible & Coinsurance
	GLP1 Medication (For Qualifying Members, Not Covered for Weight Loss)	$200 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments See Formulary 90-day supply	**Generic**	$20 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs	$180 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs	$220 Copay	OON Deductible & Coinsurance
	GLP1 Medication (For Qualifying Members, Not Covered for Weight Loss)	$600 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available

RX Benefit Highlights	
RX Company	ProAct
Phone	1-877-635-9545
Website	https://secure.proactrx.com/
Pharmacy Advantage Formulary	MM and HSA Formulary
Telehealth and Mail Order Formulary	Telehealth and Mail Order Formulary
Pharmacy Exclusions	Pharmacy Exclusions
Additional Information	https://info.proactrx.com/welcome-lx-mm