LIFEX RESEARCH CORP

Summary of Benefits & Coverage

$750/$1,500 Deductible

Rates effective as of January 1, 2026
PPO In-Network

Network Options:
PHCS PPO

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Professional Services	PPO In-Network Benefits	Out-Of-Network 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	$750 $1,500	$750 $1,500
Out-of-Pocket Maximum - Including Deductible • Individual • Family	$9,200 $18,400	$9,200 $18,400
PCP Office Visit	$50 Copay (After Deductible)	Copay + 10% After Deductible
Specialist Office Visit (No Referral Needed)	$50 Copay (After Deductible)	Copay + 10% After Deductible
Urgent Care Office Visit	$50 Copay (After Deductible)	Copay + 10% After Deductible
Surgery Performed in the Office	See Outpatient Surgery	Copay + 10% After Deductible
Chiropractic Care 12 visits per calendar year maximum	$50 Copay (After Deductible)	Copay + 10% After Deductible
Therapies: Physical, Speech, Occupational, Cardiac & Respiratory 16 visits per calendar year maximum combined	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Labs (Independent Lab Only)	$25 Copay	Copay + 10% After Deductible
X-rays (Stand Alone Radiology Only)	$50 Copay	Copay + 10% After Deductible
Diagnostic Testing/Advanced Imaging (Pre-certification Required)	$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
Emergency Services (Pre-certification is required within 48 hours of admission, if admitted)	Participating Provider	Non-Participating Provider
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
Ambulance - Land **Ambulance** - Air (2 per Benefit Plan Year Combined)	$250 Copay (After Deductible) $1,000 Copay (After Deductible)	Copay + 10% After Deductible
Inpatient or Partial Hospitalization Services (Precertification Required)	Participating Provider	Non-Participating Provider
Inpatient Hospital Care Facility or **Partial Hospitalization**	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible
Inpatient Surgical Services	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
Associated/Incidental Inpatient Services (Includes Anesthesia, Pathology, Physician Services, and any other incurred services)	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible
Inpatient Skilled Nursing Facility	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible
Inpatient Rehabilitation Facility	$50 Copay/Day (After Deductible)	Copay + 10% After Deductible

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Hospice 30-day limit per Lifetime	$0 Copay (After Deductible)	Copay + 10% After Deductible
Organ Transplant	$2,500 Copay/Admission (After Deductible)	Copay + 10% After Deductible
Outpatient Services (Precertification Required)	Participating Provider	Non-Participating Provider
Outpatient Surgical Services (Outpatient Hospital, Surgery Center or Office)	$2,500 Copay/Surgery (After Deductible)	Copay + 10% After Deductible
Surgery Services (Surgeon, anesthesia, and any other incurred services associated with outpatient surgery)	$250 Copay/Service (After Deductible)	Copay + 10% After Deductible
Outpatient Chemotherapy and Radiotherapy	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Infusion / Injection	$250 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Dialysis	$250 Copay (After Deductible)	Copay + 10% After Deductible
Outpatient Labs (No Pre-certification Required)	$100 Copay (After Deductible)	Copay + 10% After Deductible
Preventive Services	Participating Provider	Non-Participating Provider
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
Maternity Services	Participating Provider	Non-Participating Provider
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
Other Covered Services	Participating Provider	Non-Participating Provider
Home Health Care Visits (Pre-certification Required) 10 visits per Benefit Year	$50 Copay/Visit (After Deductible)	Copay + 10% After Deductible
Durable Medical Equipment (DME) (Precertification Required) Copayment is applied per item received. 5 items /benefit period.	$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
Prosthetics (Pre-certification Required) (1 item per Benefit Plan Year)	$50 Copay/Item (After Deductible)	Copay + 10% After Deductible
All other Covered Services	90% After Deductible	Copay + 10% After Deductible

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Allergies • Shots/Serum • Visits/Testing	$25 Copay (After Deductible) $50 Copay/Visit (After Deductible)		Copay + 10% After Deductible
Prescription Drugs	Participating Provider		Non-Participating Provider
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
	Generic Drugs - Urgent Care Rx (See Formulary)	$0 Copay	Copay + 10% After Deductible
	Generic Drugs - Maintenance Rx (See Formulary)	$0 Copay	Copay + 10% After Deductible
	Preferred Brand Name Drugs	PAP Available	Not Covered
	Non-Preferred Brand Name Drugs	PAP Available	Not Covered
	Specialty Drugs	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
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Not Covered
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Not Covered
	Specialty Drugs	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		
Mail Order/Telehealth	Mail Order/Telehealth		

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	
NETWORK	**PHCS**
AGES 18-29	
Employee	$409.00
Employee + Spouse	$769.00
Employee + Child(ren)	$759.00
Family	$1,039.00
AGES 30-44	
Employee	$469.00
Employee + Spouse	$799.00
Employee + Child(ren)	$789.00
Family	$1,089.00
AGES 45-54	
Employee	$499.00
Employee + Spouse	$839.00
Employee + Child(ren)	$829.00
Family	$1,149.00
AGES 55-64	
Employee	$549.00
Employee + Spouse	$869.00
Employee + Child(ren)	$849.00
Family	$1,169.00

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