LIFEX RESEARCH CORP

# Summary of Benefits & Coverage

## $500/$1,000 Deductible

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

Network Options:
PHCS PPO

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# Summary of Benefits & Coverage

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| Professional Services | PPO In-Network Benefits | Out-Of-Network<br>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**<br>• Individual<br>• Family | $500<br>$1,000 | $500<br>$1,000 |
| **Out-of-Pocket Maximum - Including Deductible**<br>• Individual<br>• Family | $9,200<br>$18,400 | $9,200<br>$18,400 |
| **PCP Office Visit** | $50 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Specialist Office Visit** (No Referral Needed) | $50 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Urgent Care Office Visit** | $50 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Surgery Performed in the Office** | See Outpatient Surgery | Copay + 10% After Deductible |
| **Chiropractic Care**<br>12 visits per calendar year maximum | $50 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Therapies:** Physical, Speech, Occupational, Cardiac & Respiratory<br>16 visits per calendar year maximum combined | $50 Copay/Visit<br>(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**<br>**Primary and Urgent Care, Behavioral Health**<br>Call: 940-LIVE-DOC (940-548-3362) to get started | $0 Copay<br>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**<br>Please note that for a true medical emergency, any provider may be used | $1,000 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Ambulance -** Land<br>**Ambulance** - Air (2 per Benefit Plan Year Combined) | $250 Copay (After Deductible)<br>$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<br>(After Deductible) | Copay + 10% After Deductible |
| **Inpatient Surgical Services** | $2,500 Copay/Surgery<br>(After Deductible) | Copay + 10% After Deductible |
| **Associated/Incidental Inpatient Services**<br>(Includes Anesthesia, Pathology, Physician Services, and any other incurred services) | $250 Copay/Service<br>(After Deductible) | Copay + 10% After Deductible |
| **Inpatient Skilled Nursing Facility** | $50 Copay/Day<br>(After Deductible) | Copay + 10% After Deductible |
| **Inpatient Rehabilitation Facility** | $50 Copay/Day<br>(After Deductible) | Copay + 10% After Deductible |

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|---|---|---|
| **Hospice**<br>30-day limit per Lifetime | $0 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Organ Transplant** | $2,500 Copay/Admission<br>(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<br>(After Deductible) | Copay + 10% After Deductible |
| **Surgery Services**<br>(Includes surgeon, anesthesia, and any other incurred services associated with outpatient surgery) | $250 Copay/Service<br>(After Deductible) | Copay + 10% After Deductible |
| **Outpatient Chemotherapy and Radiotherapy** | $250 Copay/Visit<br>(After Deductible) | Copay + 10% After Deductible |
| **Infusion / Injection** | $250 Copay/Visit<br>(After Deductible) | Copay + 10% After Deductible |
| **Dialysis** | $250 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Outpatient Labs** (No Pre-certification Required) | $100 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Preventive Services** | Participating Provider | Non-Participating Provider |
| **Preventive Care**<br>Including but not limited to: Annual Wellness Exams, Labs and Immunizations<br>See Preventative Care Guide | $0 Copay<br>$0 Deductible | Copay + 10% After Deductible |
| **Maternity Services** | Participating Provider | Non-Participating Provider |
| **Pregnancy, Maternity**<br>• Routine Delivery (Vaginal or C-Section)<br>• 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<br>(After Deductible)<br><br>100% Covered | Copay + 10% After Deductible |
| **Other Covered Services** | Participating Provider | Non-Participating Provider |
| **Home Health Care Visits** (Pre-certification Required)<br>10 visits per Benefit Year | $50 Copay/Visit<br>(After Deductible) | Copay + 10% After Deductible |
| **Durable Medical Equipment (DME)** (Precertification Required)<br>Copayment is applied per item received. 5 items /benefit period. | $50 Copay/Item<br>(After Deductible) | Copay + 10% After Deductible |
| **Diabetic Nutritional Counseling** (1 visit per plan year) | $0 Copay<br>(After Deductible) | Copay + 10% After Deductible |
| **Prosthetics** (Pre-certification Required)<br>(1 item per Benefit Plan Year) | $50 Copay/Item<br>(After Deductible) | Copay + 10% After Deductible |
| **All other Covered Services** | 90% After Deductible | Copay + 10% After Deductible |

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|---|---|---|---|
| **Allergies**<br>• Shots/Serum<br>• Visits/Testing | $25 Copay<br>(After Deductible)<br><br>$50 Copay/Visit<br>(After Deductible) | | Copay + 10% After Deductible |
| **Prescription Drugs** | Participating Provider | | Non-Participating Provider |
| **Retail Pharmacy Copayments**<br><br>30-day supply at retail pharmacies<br><br>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**<br><br>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 | | |

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| 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** | $429.00 |
| **Employee + Spouse** | $789.00 |
| **Employee + Child(ren)** | $779.00 |
| **Family** | $1,059.00 |
| **AGES 30-44** | |
| **Employee** | $489.00 |
| **Employee + Spouse** | $829.00 |
| **Employee + Child(ren)** | $819.00 |
| **Family** | $1,119.00 |
| **AGES 45-54** | |
| **Employee** | $519.00 |
| **Employee + Spouse** | $869.00 |
| **Employee + Child(ren)** | $859.00 |
| **Family** | $1,169.00 |
| **AGES 55-64** | |
| **Employee** | $569.00 |
| **Employee + Spouse** | $889.00 |
| **Employee + Child(ren)** | $869.00 |
| **Family** | $1,209.00 |

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