LIFEX RESEARCH CORP

Summary of Benefits & Coverage

VL $1,500/$3,000 Deductible

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

Network Options:
PHCS PPO

**This plan is underwritten by Benefit Logistics Captive Insurance Co, Inc NAIC # 17633 and not by PHCS Licensee

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NETWORK	INN
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	See Services Performed
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	 $1,500 $3,000
Out-of-Pocket Maximum (For member accumulated deductible and copays (Individual/Family) Out of Pocket – Maximum for services beyond the plan visit limits	$10,600 $21,200 Unlimited
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 • 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. Emergencies are covered but do require authorization/certification within 48 hours.	
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 10 visits per benefit year maximum is combined for PCP office visits, Specialist Office visits, and Urgent Care visits. 12 visits per benefit year maximum for Chiropractic Care. • Primary Care Physician • Specialist Office Visit • Urgent Care Visit • Chiropractic Care • Surgery Performed in the Office (See Outpatient Surgery)	$50 Copay 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

Emergency Services
• Emergency Room Care
  ◦ 2-visit limit per benefit year for accident-related visits
  ◦ 2-visit limit per benefit year for sickness-related visits
• Observation Room Hospital
• Emergency Medical Transportation
  ◦ Ground/Air Ambulance: 2 per benefit plan year combined
	$500 Copay After Deductible
	
	$750 Copay After Deductible
	
	$250 Copay After Deductible (Ground)/ $1,000 Copay After Deductible (Air)

Diagnostic Testing/Advanced Imaging (Precertification Required) 3 per benefit year	$200 Copay After Deductible
Labs (3 per Benefit Plan Year In-Office and 3 per Benefit Plan Year Outpatient)	$25 Copay After Deductible
X-rays (3 per Benefit Plan Year)	$50 Copay After Deductible

Outpatient Facility Services (Precertification Required)
• Infusions/Injections
  ◦ 10-visit limit per benefit year; maximum combined with chemotherapy/radiation
• Outpatient Surgical Services (Outpatient hospital, Surgery Center of Office)
  ◦ 3 surgeries per benefit year (Surgeon, anesthesia and any other incurred services associated with outpatient surgery)
• Outpatient Chemotherapy and Radiotherapy
  ◦ 10-visit limit per benefit year; maximum combined with infusion/injection drugs
• Dialysis
	$100 Copay/Visit After Deductible
	
	$250 Copay/Service After Deductible
	
	$100 Copay/Visit After Deductible
	
	Not Covered

Inpatient Hospital Services (Precertification Required) **Inpatient Hospital Care Facility** Stays Limited To: 10 days per admission (ICU and non-ICU), 3 hospitalizations per benefit period. **Associated/Incidental Inpatient Services** (Anesthesia, Pathology, Physician Services, and any other incurred services)	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible

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Inpatient Services (Precertification Required) **Inpatient Hospital Surgical Services**, All Fees 2 surgeries per plan year **Inpatient Rehabilitation Facility** 10-day limit per benefit year	$1,000 Copay/Surgery After Deductible $50 Copay/Day After Deductible
Preventive Services - Click here for a complete list.	
Preventive Care/Screening/Immunization Including but not limited to: Annual Wellness Exams Labs and Immunizations See Preventative Care Guide	$0 Copay $0 Deductible
Other Covered Services	
Therapy 16 visits per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy • ABA & Respiratory	$50 Copay/Visit After Deductible
Pregnancy/Maternity • Routine Delivery • Including all Routine Maternity Service (Office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded: Genetic testing, unless medically necessary.)	$500 Copay After Deductible
Home Health Care (Precertification Required) 10-day limit per benefit year	$50 Copay/Visit After Deductible
Hospice Care 30-day limit per lifetime	$0 Copay After Deductible
Inpatient Skilled Nursing Facility (Precertification Required) 10-day visit limit per benefit year	$50 Copay/Day After Deductible
Durable Medical Equipment (DME)/ Medical Supplies (Precertification Required) Copayment is applied per item received. 5 items/benefit period.	$50 Copay/Item After Deductible
Prosthetics (Precertification Required) 1 item per benefit year	$500 Copay/Item After Deductible
Organ Transplant	Not Covered

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Nutritional Counseling 1 visit per benefit year		$0 Copay After Deductible
Allergies • Shots/Serum (24 visits per benefit year) • Visits/Testing (2 visits per benefit year)		$50 Copay After Deductible $50 Copay/Visit After Deductible
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** Generic or Brand Name	$0 Copay
	Generic Maintenance Rx	$0 Copay
	Generic Urgently Needed Care Rx	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available
	Specialty Drugs	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments See Formulary 90-day supply	**Generic**	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available
	Specialty Drugs	Patient Assistance Plans Available
RX Benefit Highlights		
Rx Company		ProAct
Phone 24/7/365		1-877-635-9545
Website		https://secure.proactrx.com/
Formulary		https://bit.ly/4j9crFR
Mail Order/TeleHealth		https://bit.ly/4j9crFR

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PREMIUMS BY AGE BAND	
NETWORK	**PHCS**
AGES 18-29	
Employee	$267.00
Employee + Spouse	$596.00
Employee + Child(ren)	$586.00
Family	$844.00
AGES 30-44	
Employee	$318.00
Employee + Spouse	$627.00
Employee + Child(ren)	$611.00
Family	$885.00
AGES 45-54	
Employee	$359.00
Employee + Spouse	$679.00
Employee + Child(ren)	$658.00
Family	$957.00
AGES 55-64	
Employee	$411.00
Employee + Spouse	$710.00
Employee + Child(ren)	$668.00
Family	$977.00