PLAN COMPARISON:
Summary of Benefits & Coverage

LIFEX RESEARCH CORP

Rates effective as of January 1, 2026
Network Options: PHCS PPO
**This plan is underwritten by Benefit Logistics Captive Insurance Co, Inc NAIC # 17633 and not by PHCS Licensee

VL $250/$500 Deductible **Only available for renewal for current LifeX Employees

VL $500/$1,000 Deductible

VL $750/$1,500 Deductible

VL $1,000/$2,000 Deductible

VL $1,500/$3,000 Deductible

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PLAN	VL $250	VL $500	VL $750	VL $1,000	VL $1,500
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	See Services Performed	See Services Performed	See Services Performed	See Services Performed
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	 $250 $500	 $500 $1,000	 $750 $1,500	 $1,000 $2,000	 $1,500 $3,000
Out-of-Pocket Maximun (For member accumulated deductible and copays (Individual/Family) Out of Pocket – Maximum for services beyond the plan visit limits	$10,150 $20,300 Unlimited	$10,150 $20,300 Unlimited	$10,150 $20,300 Unlimited	$10,150 $20,300 Unlimited	$10,150 $20,300 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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PLAN	VL $250	VL $500	VL $750	VL $1,000	VL $1,500
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 • Spinal Manipulation Chiropractic • Surgery Performed in the Office (See Outpatient Surgery)	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$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	$0 Copay Unlimited Visits	$0 Copay Unlimited Visits	$0 Copay Unlimited Visits	$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 year
Please note that for a true medical emergency, any provider may be used.
	$500 Copay After Deductible
	
	$750 Copay After Deductible
	
	$250 Copay After Deductible (Ground)/ $1,000 Copay After Deductible (Air)
		$500 Copay After Deductible
		
		$750 Copay After Deductible
		
		$250 Copay After Deductible (Ground)/ $1,000 Copay After Deductible (Air)
			$500 Copay After Deductible
			
			$750 Copay After Deductible
			
			$250 Copay After Deductible (Ground)/ $1,000 Copay After Deductible (Air)
				$500 Copay After Deductible
				
				$750 Copay After Deductible
				
				$250 Copay After Deductible (Ground)/ $1,000 Copay After Deductible (Air)
					$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	$200 Copay	$200 Copay	$200 Copay	$200 Copay
Labs (3 per Benefit Plan Year In-Office and 3 per Benefit Plan Year Outpatient)	$25 Copay After Deductible	$25 Copay After Deductible	$25 Copay After Deductible	$25 Copay After Deductible	$25 Copay After Deductible
X-rays (3 per Benefit Plan Year)	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible

Outpatient Facility Services (Precertification Required)
• Infusions/Injections
  ◦ 10-visit limit per benefit year; maximum combined with chemotherapy/radiation
• Surgical Services
  ◦ 3 surgeries per benefit year (includes 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 After Deductible
	
	$250 Copay After Deductible
	
	$100 Copay After Deductible
	
	Not Covered
		$100 Copay After Deductible
		
		$250 Copay After Deductible
		
		$100 Copay After Deductible
		
		Not Covered
			$100 Copay After Deductible
			
			$250 Copay After Deductible
			
			$100 Copay After Deductible
			
			Not Covered
				$100 Copay After Deductible
				
				$250 Copay After Deductible
				
				$100 Copay After Deductible
				
				Not Covered
					$100 Copay After Deductible
					
					$250 Copay After Deductible
					
					$100 Copay After Deductible
					
					Not Covered

Inpatient Services (Precertification Required) Stays Limited To: 2 ICU hospitalizations per benefit period and 2 Non-ICU hospitalizations per benefit period.(10-day limit per ICU hospitalization, 10-day limit per Non-ICU hospitalization) ASSOCIATED/INCIDENTAL INPATIENT SERVICES (Included Anesthesia, Pathology, Physician Services, and any other incurred services)	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible	$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	$1,000 Copay/Surgery After Deductible $50 Copay/Day After Deductible	$1,000 Copay/Surgery After Deductible $50 Copay/Day After Deductible	$1,000 Copay/Surgery After Deductible $50 Copay/Day After Deductible	$1,000 Copay/Surgery After Deductible $50 Copay/Day After Deductible
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 Copay	$0 Copay	$0 Copay	$0 Copay
Other Covered Services					
Therapy 16 visits per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Pregnancy, Maternity • Routine Vaginal Delivery • Routine C-section Delivery • All Other Maternity Service (Other maternity services included: office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded: Genetic testing, unless medically necessary.)	$500 Copay After Deductible $500 Copay After Deductible 100% Covered	$500 Copay After Deductible $500 Copay After Deductible 100% Covered	$500 Copay After Deductible $500 Copay After Deductible 100% Covered	$500 Copay After Deductible $500 Copay After Deductible 100% Covered	$500 Copay After Deductible $500 Copay After Deductible 100% Covered
Home Health Care (Precertification Required) 10-day limit per benefit year	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible	$50 Copay After Deductible
Hospice Care 30-day limit per lifetime	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Inpatient Skilled Nursing Facility (Precertification Required) 10-day visit limit per benefit year	$50 Copay/Day After Deductible	$50 Copay/Day After Deductible	$50 Copay/Day After Deductible	$50 Copay/Day After Deductible	$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	$50 Copay/Item After Deductible	$50 Copay/Item After Deductible	$50 Copay/Item After Deductible	$50 Copay/Item After Deductible
Prosthetics (Precertification Required) 1 item per benefit year	$500 Copay/Item After Deductible	$500 Copay/Item After Deductible	$500 Copay/Item After Deductible	$500 Copay/Item After Deductible	$500 Copay/Item After Deductible
Organ Transplant	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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PLAN		VL $250	VL $500	VL $750	VL $1,000	VL $1,500
Diabetic Nutritional Counseling 1 visit per benefit year		$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible	$0 Copay After Deductible	$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 After Deductible	$50 Copay After Deductible $50 Copay After Deductible	$50 Copay After Deductible $50 Copay After Deductible	$50 Copay After Deductible $50 Copay After Deductible	$50 Copay After Deductible $50 Copay After Deductible
Prescription Drugs						
Retail Pharmacy Copayments 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	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Generic Maintenance Rx	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Generic Urgently Needed Care Rx	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments 90-day supply	**Generic**	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	Patient Assistance Plans Available	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					
PLAN	**VL $250**	**VL $500**	**VL $750**	**VL $1,000**	**VL $1,500**
NETWORK	**PHCS**	**PHCS**	**PHCS**	**PHCS**	**PHCS**
AGES 18-29					
Employee	$349.00	$329.00	$308.00	$287.00	$267.00
Employee + Spouse	$679.00	$658.00	$638.00	$617.00	$596.00
Employee + Child(ren)	$699.00	$648.00	$627.00	$607.00	$586.00
Family	$957.00	$905.00	$885.00	$864.00	$844.00
AGES 30-44					
Employee	$421.00	$390.00	$370.00	$349.00	$318.00
Employee + Spouse	$751.00	$699.00	$668.00	$648.00	$627.00
Employee + Child(ren)	$730.00	$689.00	$658.00	$638.00	$611.00
Family	$998.00	$967.00	$936.00	$905.00	$885.00
AGES 45-54					
Employee	$452.00	$421.00	$401.00	$380.00	$359.00
Employee + Spouse	$761.00	$741.00	$710.00	$689.00	$679.00
Employee + Child(ren)	$751.00	$730.00	$699.00	$679.00	$658.00
Family	$1,050.00	$1,019.00	$998.00	$977.00	$957.00
AGES 55-64					
Employee	$504.00	$473.00	$452.00	$432.00	$411.00
Employee + Spouse	$782.00	$761.00	$741.00	$720.00	$710.00
Employee + Child(ren)	$761.00	$741.00	$720.00	$710.00	$668.00
Family	$1,080.00	$1,060.00	$1,019.00	$998.00	$977.00