LifeX Research Corporation: Visit Limit Plan

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2026 - 12/31/2026

Coverage for: Individual + Family | **Plan Type**: VL

This is not a policy.

You can get the policy at www.lifexresearch.com or by calling Benefit Health Plan, Inc at 1-844-580-2474.

A Summary Plan Description has more detail about how to use the plan and what you and your employer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why This Matters:
What is the premium?	The premium is the amount paid for health insurance.	This is only an estimate based on the information you've provided. After the insurer reviews your application, your actual premium may be higher, or your application may be denied.
What is the overall deductible?	Individual: $250 - $1,500 Family: $500 - $3,000	Please see plan coverage for applicable deductible level chosen.
Are there other deductibles for specific services?	No.	
Is there an out-of-pocket limit on my expenses?	Individual: $10,600 Family: $21,200	The out-of-pocket limit is the most you could pay during a policy period for member accumulated deductible and copays / your share of the cost of covered services. Maximum out-of-pocket for services beyond the plan visit limits = unlimited.
What is not included in the out-of-pocket limit?	Premium, balanced-billed charges, and health care visits beyond the plan visit limit.	Contributions to those mentioned in the answers section do not count toward the out-of-pocket limit.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. Search your chosen network for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all the costs of covered services. If you use an out-of-network doctor or other health care provider, this plan will not pay for any claims out-of-network. Plans use the term in-network, preferred, or participating for providers in their network. *Some services may be subject to pre-certification.*
Do I need a referral to see a specialist?	No.	You can see a specialist of your choosing without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See full plan document for an entire list of not covered services.

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Co-payments: Fixed amount you pay for a covered health care service (such as $50 for primary care or $50 for specialty care). Usually, you pay at the time you receive the service. In some cases, the copayment applies after you meet the deductible.

Co-insurance: Your share of the costs of a covered service, this is calculated as a percentage of the allowed amount for the service received. *This plan does not include co-insurance.*

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider Cost	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary Care visit to treat an injury or illness	$50 Copay After Deductible	Not Covered	
	Specialist Visit	$50 Copay After Deductible	Not Covered	
	Chiropractic Care	$50 Copay After Deductible	Not Covered	12 Visit Limit/calendar year
	Preventative care / Screening / Immunization	$0 Copay / $0 Deductible	Not Covered	Including but not limited to: Annual Wellness Exams, Labs, Immunizations. See Preventative Care Guide
	Therapies (Physical, Speech, Occupational, Cardiac & Respiratory)	$50 Copay/Visit After Deductible	Not Covered	16 Visit Limit/calendar year combined
	Telemedicine (Through OurLiveDoc ONLY)	$0 Copay / Unlimited Visits	Not Covered	Primary & Urgent Care, Behavioral Health Call: 940-LIVE-DOC (940-548-3362) to get started
	Urgent Care Office Visit	$50 Copay After Deductible	Not Covered	
If you have a test	X-Ray Lab	$50 Copay After Deductible $25 Copay After Deductible	Not Covered	3/Benefit Plan Year 3/Benefit Plan Year in Office and 3 Outpatient
	Imaging (CT/PET Scans, MRIs)	$200 Copay After Deductible	Not Covered	Precertification Required 3/Benefit Plan Year

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		Participating Provider Cost	Non-Participating Provider	
Emergency Services	Emergency Room Care	$500 Copay After Deductible	Not Covered	2/Benefit Year for Accident-Related Visits 2/Benefit Year for Sickness-Related Visits
	Ambulance: Land/Air	$250 Copay After Deductible $1,000 Copay After Deductible	Not Covered	2/Benefit Plean Year Combined
If you have a hospital stay	Inpatient Facility	$1,000 Copay/Admission After Deductible	Not Covered	Precertification Required 10 Days/Admission (ICU and Non-ICU) 3 Hospitalizations/Benefit Year
	Inpatient Surgical Services	$1,000 Copay/Surgery After Deductible	Not Covered	Precertification Required 2 Surgeries/Plan Year
	Associated/Incidental Inpatient Services	$250 Copay/Service After Deductible	Not Covered	Precertification Required Includes anethessia, pathology, physician services, and any other incurred services)
	Inpatient Skilled Nursing Facility	$50 Copay/Day After Deductible	Not Covered	Precertification Required 10 Days/Benefit Year
	Inpatient Rehabilitation Facility	$50 Copay/Day After Deductible	Not Covered	Precertification Required 10 Days/Benefit Year
	Hospice Care	$0 Copay After Deductible	Not Covered	30-day Limit/Lifetime
	Organ Transplant	Not Covered	Not Covered	

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		Participating Provider Cost	Non-Participating Provider	
If you have outpatient surgery	Outpatient Surgical Services (Facility)	$250 Copay/Service After Deductible	Not Covered	Precertification Required 3 Surgeries/Benefit Year (Includes surgeon, anesthesia, and any other associated incurred services)
	Outpatient Chemotherapy and Radiotherapy	$100 Copay/Visit After Deductible	Not Covered	Precertification Required 10 Visits/Benefit Year Combined with infusion/injection drugs
	Infusion/Injection	$100 Copay/Visit After Deductible	Not Covered	Precertification Required 10 Visits/Benefit Year Combined with Chemo/Radiation
If you become pregnant	Routine Delivery	$500 Copay After Deductible	Not Covered	
	All other routine maternity services (Including office visits, labs, radiology, prenatal/postnatal care)	$500 Copay After Deductible	Not Covered	Excluding: Genetic testing unless medically necessary.
If you have a recovery or other special health need	Home Health Care	$50 Copay/Visit After Deductible	Not Covered	Precertification Required. 10 visits/Benefit Year
	Durable Medical Equipment	$50 Copay/Item After Deductible	Not Covered	Precertification Required. Copayment is applied/item received. 5 items / benefit period.
	Allergies: Shots & Serums / Visits & Testing	$50 Copay After Deductible/ $50 Copay/Visit After Deductible	Not Covered	24 Visits/Benefit Year/ 2 Visits/Benefit Year

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider Cost	Non-Participating Provider	
If you need drugs to treat your illness or condition (RETAIL PHARMACY) 30-day supply at retail pharmacies. See Formulary.	Preventive Medicine Rx - Generic or Brand	$0 Copay	Not Covered	Mail order required for maintenance medication after initial 30-day supply.
	Generic Drugs - Urgent Rx	$0 Copay	Not Covered	
	Generic Drugs - Maintenance Rx	$0 Copay	Not Covered	
	Preferred Brand Name Drugs	PAP Available	Not Covered	
	Non-Preferred Brand Name Drugs	PAP Available	Not Covered	
	Specialty Drugs	PAP Available	Not Covered	
If you need drugs to treat your illness or condition (MAIL ORDER OR RETAIL PHARMACY) 90-day supply maintenance medication See Formulary.	Generic Drugs	$0 Copay	Not Covered	
	Preferred Brand Name Drugs	PAP Available	Not Covered	
	Non-Preferred Brand Name Drugs	PAP Available	Not Covered	
	Specialty Drugs	PAP Available	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Bariatric Surgery
- Non-Emergency care when traveling outside of the U.S.
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Private-duty nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Chiropractic Care

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- You commit fraud
- The insurer stops offering services in the state
- You move outside the coverage area

Your Grievance and Appeals Rights:

- A **grievance** is complaint you have about your plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health plan. Call 844-580-2474 or visit www.lifexresearch.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 844-580-2474 or visit www.lifexresearch.com.

Does this Coverage Provide Minimum Essential Coverage?

The ACA (Affordable Care Act) requires most individuals to maintain health care coverage that qualifies as MEC (Minimum Essential Coverage). This health coverage meets the MEC (Minimum Essential Coverage) requirements.

Does this Coverage Meet the Minimum Value Standard?

The ACA (Affordable Care Act) establishes a minimum value standard for health coverage benefits. This standard requires health coverage to have an actuarial value of at least 60%. This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how these benefits might cover medical care in these situations. Use these examples to see, in general, how much protection you might get from different health benefits.

This is not a cost estimator.
Don't use these examples to estimate your actual costs under this coverage. The actual care you receive will be different from these examples, and the cost of that care also will be different.
See the next page for important information about these examples.

HAVING A BABY
(Normal Delivery, In-Network)

- **Amount owed to providers:** $8,100
- **Plan Pays:** $5,600
- **You Pay:** $2,500

Sample Care Costs:

First Office Visit	$100
Radiology	$300
Laboratory Tests	$200
Routine Obstetric Care	$2,000
Hospital Charges (Mother)	$4,100
Anesthesia	$1,000
Circumcision	$200
Vaccines, Other Preventive	$200
TOTAL	**$8,100**

You Pay:

Deductibles	$1,000
Copays	$1,500
Co-Insurance	$0
Limits or Exclusions	$0
TOTAL	**$2,500**

RESPONSIBLE FOR ALL DEDUCTIBLES, COPAYS, and COINSURANCE

TREATING BREAST CANCER
(Lumpectomy, Chemotherapy, Radiation, In-Network)

- **Amount owed to providers:** $117,800
- **Plan Pays:** $114,050
- **You Pay:** $3,750

Sample Care Costs:

Office Visits & Procedures	$4,000
Radiology	$4,000
Laboratory Tests	$2,400
Hospital Charges	$3,300
Inpatient Medical Care	$20,000
Outpatient Surgery	$3,400
Chemotherapy	$64,000
Radiation Therapy	$13,000
Prostheses (Wig)	$500
Pharmacy	$2,000
Mental Health	$1,200
TOTAL	**$117,800**

You Pay:

Deductibles	$1,000
Copays	$2,750
Co-Insurance	$0
Limits or Exclusions	**May Apply
TOTAL	**$3,750**

RESPONSIBLE FOR ALL DEDUCTIBLES, COPAYS, and COINSURANCE

MANAGING DIABETES
(Routine maintenance of existing condition. In-network)

- **Amount owed to providers:** $7,800
- **Plan Pays:** $6,575
- **You Pay:** $1,225

Sample Care Costs:

Office Visits & Procedures	$960
Laboratory Tests	$300
Medical Equipment & Supplies	$40
Pharmacy (Oral Only)	$6,500
TOTAL	**$7,800**

You Pay:

Deductibles	$1,000
Copays	$225
Co-Insurance	$0
Limits or Exclusions	**May Apply
TOTAL	**$1,225**

RESPONSIBLE FOR ALL DEDUCTIBLES, COPAYS, and COINSURANCE

Questions and Answers about Coverage Examples:

Question	Answer
What are some of the assumptions behind the Coverage Examples?	• Costs don't include premiums. • Sample care costs are based on national averages supplied to the U.S,. Department of Health and Human Services (HHS) and aren't specific to a particular geographic area or health plan. • Patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same policy period. • There are no other medical expenses for any member covered under these benefits. Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
What does a Coverage Example Show?	For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.
Does the Coverage Example predict my own care needs?	**No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.
Does the Coverage Example predict my future expenses?	**No.** Coverage examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Questions and Answers about Coverage Examples:

Question	Answer
Can I use Coverage Examples to compare plans?	**Yes.** When you look at the Summaries of Coverage for other coverage, you'll find the same coverage examples. When you compare benefits, check the "You Pay" box for each example. The smaller that number, the more coverage provided.
Are there other costs I should consider when comparing plans?	**Yes.** An important cost is the premium you pay.Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.