LIFEX RESEARCH CORP

Summary of Benefits & Coverage

EPO $1,500/$3,000 MM Deductible

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

Network Options:
CIGNA EPO

*This plan is underwritten by Benefit Logistic Captive Insurance Co, Inc NAIC #17633 and not by Cigna.

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Professional Services	PPO In-Network Benefits
In-network Provider: The provider network is shown on your I.D. card. For help locating in-network providers, click here.	
Deductible • Individual • Family	 $1,500 $3,000
Out-of-Pocket Maximum - Including Deductible • Individual • Family	 $9,200 $18,400
PCP Office Visit	$50 Copay (After Deductible)
Specialist Office Visit (No Referral Needed)	$50 Copay (After Deductible)
Urgent Care Office Visit	$50 Copay (After Deductible)
Surgery Performed in the Office	See Outpatient Surgery
Chiropractic Care 12 visits per calendar year maximum	$50 Copay (After Deductible)
Therapies: Physical, Speech, Occupational, Cardiac & Respiratory 16 visits per calendar year maximum combined	$50 Copay/Visit (After Deductible)
Labs	$25 Copay After Deductible
X-rays	$50 Copay After Deductible
Diagnostic Testing/Advanced Imaging (Pre-certification Required)	$200 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 (Pre-certification is required within 48 hours of admission, if admitted)	Participating Provider
Emergency Room Care Please note that for a true medical emergency, any provider may be used	$1,000 Copay (After Deductible)
Ambulance	$250 Copay (After Deductible)
Inpatient or Partial Hospitalization Services (Precertification Required)	Participating Provider
Inpatient Hospital Care Facility or **Partial Hospitalization**	$2,500 Copay/Admission (After Deductible)
Inpatient Surgical Services	$2,500 Copay/Surgery (After Deductible)
Associated/Incidental Inpatient Services (Includes Anesthesia, Pathology, Physician Services, and any other incurred services)	$250 Copay/Service (After Deductible)
Inpatient Skilled Nursing Facility	$50 Copay/Day (After Deductible)
Inpatient Rehabilitation Facility	$50 Copay/Day (After Deductible)

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

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Allergies • Shots • Visits/Testing		$25 Copay (After Deductible) $50 Copay/Visit (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 Rx - Generic or Brand** (See Formulary)	$0 Copay
	Generic Drugs - Urgent Care Rx (See Formulary)	$0 Copay
	Generic Drugs - Maintenance Rx (See Formulary)	$0 Copay
	Preferred Brand Name Drugs	PAP Available
	Non-Preferred Brand Name Drugs	PAP Available
	Specialty Drugs	PAP Available
Mail Order or Retail Pharmacy Copayments 90-day supply maintenance medication	**Generic Drugs** (See Formulary)	$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

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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