LIFEX RESEARCH CORP

Summary of Benefits & Coverage

HSA $5,000 Deductible

Rates effective as of January 1, 2025
PPO in-network and out-of-network benefits

Network Options:
PHCS PPO, Cigna PPO, or BCBS PPO (Not Currently Available)

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NETWORK	INN	OON
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	UNLIMITED	
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	$5,000 $10,000	$10,000 $20,000
Coinsurance (The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.)	20%	50%
Out-of-Pocket Limit (includes Deductible, Coinsurance, & Copayments) • Individual • Family	$8,300 $16,600	$16,600 $33,200
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 (including Mental Health Services) • 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	• Mental Health Services (except for Telemedicine) • Substance Abuse Services • 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.		
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 • Primary Care Physician • Specialist Office Visit ◦ No referral needed • Urgent Care Visit • Spinal Manipulation Chiropractic (24 visits per calendar year)	Suggested Copay: $40 20% After Deductible Suggested Copay: $75 20% After Deductible Suggested Copay: $90 20% After Deductible Suggested Copay: $75 20% After Deductible	OON Deductible & Coinsurance
Telemedicine Through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay	Not Covered
Emergency (Precertification is required within 48 hours of admission, if admitted)		
Emergency Services Please note that for a true medical emergency, any provider may be used. Emergency Ambulance Services ◦ Ground/Air Ambulance	Suggested Copay: $1000 20% After Deductible	OON Deductible & Coinsurance
Labs	$25 Copay After Deductible	OON Deductible & Coinsurance
X-rays	$100 Copay After Deductible	OON Deductible & Coinsurance
Diagnostic Testing/Advanced Imaging (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
Outpatient Facility Services (Precertification Required) • Infusions/Injections • Outpatient Surgical Facility Services • Outpatient Chemotherapy and Radiotherapy • Dialysis (limited to acute temporary dialysis)	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered
Inpatient Services (Precertification Required) • Inpatient Hospital Care Facility • Inpatient Hospital Surgical Services, All Fees • Intensive Care Unit (30 days per calendar year maximum) • Inpatient Rehabilitation Facility (30 days per calendar year maximum)	20% After Deductible	OON Deductible & Coinsurance

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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 Deductible	OON Deductible & Coinsurance
Mental Health, Behavioral Health, and/or Substance Use Disorder Services		
• Inpatient Care Mental Health Facility ◦ 30 days per benefit year maximum • Outpatient Mental Healthcare Services	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services - Illness or Injury		
Therapy 35 days per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	Suggested Copay: $75 20% After Deductible	OON Deductible & Coinsurance
Pregnancy/Maternity • Prenatal/Postnatal Office Visit • Room and Board (limited to semi-private room rate)	20% After Deductible	OON Deductible & Coinsurance
Home Health Care 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
Hospice Care 30 days per benefit year maximum • Residential/Facility	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility 30-day visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (DME) Limited to 12-month rental or purchase price, whichever is less	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered
Diabetic Nutritional Counseling (1 visit per plan year)	20% After Deductible	OON Deductible & Coinsurance
Allergy Testing/Injections	20% After Deductible	OON Deductible & Coinsurance

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NETWORK		INN	OON
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	OON Deductible & Coinsurance
	Generic Urgently Needed Care Rx	$10 Copay After Deductible	OON Deductible & Coinsurance
	Generic Maintenance Rx	$10 Copay After Deductible	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Urgently Needed Care Rx	$90 Copay After Deductible	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Urgently Needed Care Rx	$110 Copay After Deductible	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Maintenance Rx	$110 Copay After Deductible	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments 90-day supply	**Preventive Medicine** Generic or Brand Name	$0 Copay	OON Deductible & Coinsurance
	Generic	$20 Copay After Deductible	OON Deductible & Coinsurance
	Preferred Brand Name Drugs	$180 Copay After Deductible	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs	$220 Copay After Deductible	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available
RX Benefit Highlights			
RX Company		ProAct	
Phone		1-877-635-9545	
Website		https://secure.proactrx.com/	
Formulary		MM and HSA Formulary	
Telehealth and Mail Order Formulary		Telehealth and Mail Order Formulary	
Pharmacy Exclusions		Pharmacy Exclusions	
Additional Information		https://info.proactrx.com/welcome-lx-mm	

Notes:

1. Failure to obtain authorization will result in penalties. The penalty may be a 50% reduction of allowed charges or denial of claim.
2. Elective Surgery will not be covered for the first 90 days of coverage.
3. 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.
4. In the case authorization is required for an emergency admission, there is a 48-hour grace period or next business day.

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PREMIUMS BY AGE BAND			
NETWORK	**PHCS**	**CIGNA**	**BCBS (Not Currently Available)**
AGES 18-29			
Employee	$516.60	$576.60	$596.60
Employee + Spouse	$901.91	$981.91	$1,001.91
Employee + Child(ren)	$826.75	$906.75	$926.75
Family	$1,291.99	$1,391.99	$1,411.99
AGES 30-44			
Employee	$531.63	$591.63	$611.63
Employee + Spouse	$931.98	$1,011.98	$1,031.98
Employee + Child(ren)	$853.81	$933.81	$953.81
Family	$1,337.09	$1,437.09	$1,457.09
AGES 45-54			
Employee	$555.12	$615.12	$635.12
Employee + Spouse	$974.22	$1,054.22	$1,074.22
Employee + Child(ren)	$892.30	$972.30	$992.30
Family	$1,398.09	$1,498.09	$1,518.09
AGES 55-64			
Employee	$588.89	$648.89	$668.89
Employee + Spouse	$1,046.51	$1,126.51	$1,146.51
Employee + Child(ren)	$956.89	$1,036.89	$1,056.89
Family	$1,508.89	$1,608.89	$1,628.89