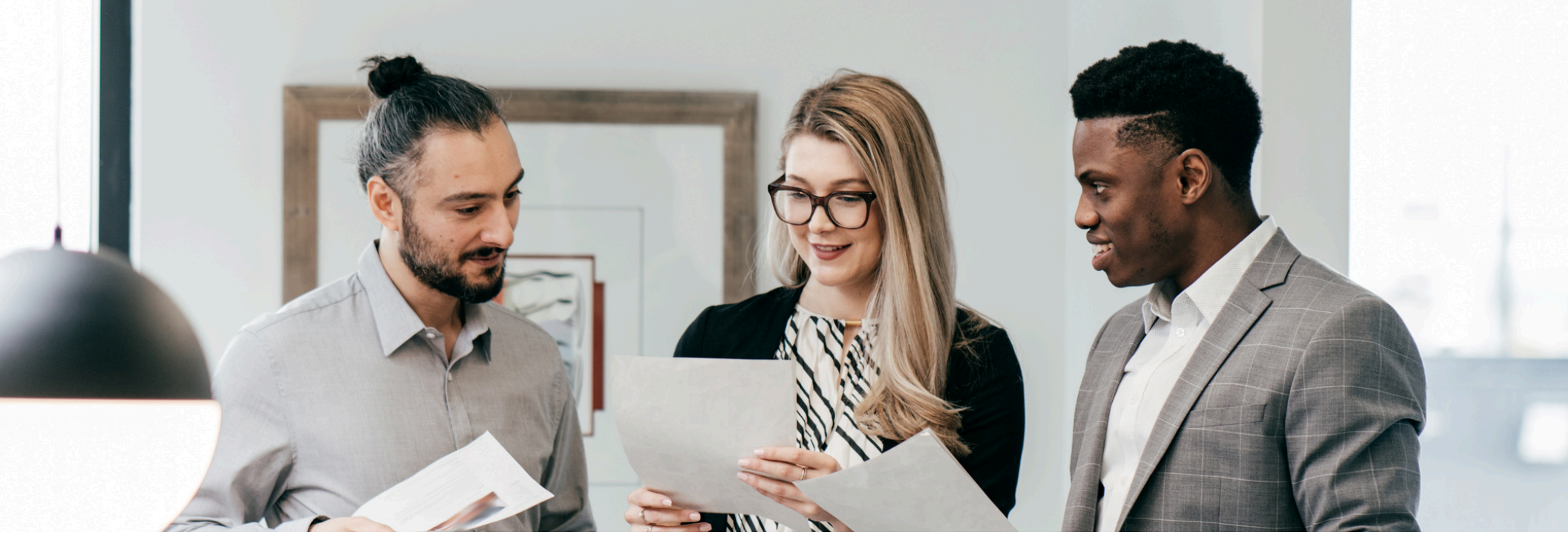

PLAN COMPARISON:
Summary of Benefits & Coverage

LIFEX RESEARCH CORP

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

MM $1,000 Deductible

MM $2,500 Deductible

MM $3,500 Deductible

PHCS PPO, Cigna PPO, or Anthem PPO

Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025

PLAN	MM $1,000		MM $2,500		MM $3,500	
NETWORK	**INN**	**OON**	**INN**	**OON**	**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		Unlimited		Unlimited	
Deductible The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable. • Individual • Family	$1,000 $2,000	$5,000 $10,000	$2,500 $5,000	$5,000 $10,000	$3,500 $7,000	$7,000 $14,000
Coinsurance The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.	20%	50%	20%	50%	20%	50%
Out-of-Pocket Limit (includes Deductible, Coinsurance, & Copayments) • Individual • Family	$9,200 $18,400	$18,400 $36,800	$9,200 $18,400	$18,400 $36,800	$9,200 $18,400	$18,400 $36,800
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		• 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.						

Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025

PLAN	MM $1,000		MM $2,500		MM $3,500	
NETWORK	**INN**	**OON**	**INN**	**OON**	**INN**	**OON**
Covered Services - Illness or Injury						
Physician Office Services • Primary Care Physician • Specialist Office Visit • Urgent Care Visit • Spinal Manipulation Chiropractic ◦ 24 visits per plan year	$25 Copay $40 Copay $60 Copay $30 Copay	OON Deductible & Coinsurance	$25 Copay $40 Copay $60 Copay $30 Copay	OON Deductible & Coinsurance	$25 Copay $40 Copay $60 Copay $30 Copay	OON Deductible & Coinsurance
Telemedicine Through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay	Not Covered	$0 Copay	Not Covered	$0 Copay	$0 Copay
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	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Labs	$25 Copay	OON Deductible & Coinsurance	$25 Copay	OON Deductible & Coinsurance	$25 Copay	OON Deductible & Coinsurance
X-rays	$100 Copay	OON Deductible & Coinsurance	$100 Copay	OON Deductible & Coinsurance	$100 Copay	OON Deductible & Coinsurance
Diagnostic Testing/Advanced Imaging (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Outpatient Facility Services (Precertification Required) • Infusions/Injections • Surgical Services • Outpatient Chemotherapy and Radiotherapy (30 days per calendar year) • Dialysis (limited to acute temporary dialysis)	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered	20% After Deductible	OON Deductible & Coinsurance OON Deductible & Coinsurance Not Covered Not Covered	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 plan year) • Inpatient Rehabilitation Facility (30 days per plan year)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Alcohol & Substance Abuse Care (Precertification Required)						
Alcohol & Substance Abuse • Inpatient Care (30 days per plan year) • Outpatient Services (30 days per plan year)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025

PLAN	MM $1,000		MM $2,500		MM $3,500	
NETWORK	**INN**	**OON**	**INN**	**OON**	**INN**	**OON**
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	$0 Copay $0 Deductible	OON Deductible & Coinsurance	$0 Copay $0 Deductible	OON Deductible & Coinsurance
Other Covered Services						
Therapy 30 days per plan year • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	$40 Copay	OON Deductible & Coinsurance	$40 Copay	OON Deductible & Coinsurance	$40 Copay	OON Deductible & Coinsurance
Pregnancy/Maternity • Prenatal/Postnatal Office Visit • Room and Board	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Home Health Care Visits (Precertification required) 60-visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Hospice Care (Precertification required) 30 days per benefit year • Residential/Facility	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility (Precertification required) 30-day visit limit per benefit year	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (DME) (Precertification required)	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant (Precertification required)	20% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Allergy Testing/Injections	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance	20% After Deductible	OON Deductible & Coinsurance

Plan Comparison: Summary of Benefits & Coverage

Rates effective as of January 1, 2025

PLAN		MM $1,000		MM $2,500		MM $3,500	
NETWORK		**INN**	**OON**	**INN**	**OON**	**INN**	**OON**
Prescription Drugs							
Retail Pharmacy Copayments 30-day supply at retail pharmacies Mail order required for maintenance medication after initial 30-day supply	**Generic** Urgently Needed Care Rx	$10 Copay	OON Deductible & Coinsurance	$10 Copay	OON Deductible & Coinsurance	$10 Copay	OON Deductible & Coinsurance
	Generic Maintenance Rx	$10 Copay	OON Deductible & Coinsurance	$10 Copay	OON Deductible & Coinsurance	$10 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs Urgently Needed Care Rx	$90 Copay	OON Deductible & Coinsurance	$90 Copay	OON Deductible & Coinsurance	$90 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Urgently Needed Care Rx	$110 Copay	OON Deductible & Coinsurance	$110 Copay	OON Deductible & Coinsurance	$110 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs Maintenance Rx	$110 Copay	OON Deductible & Coinsurance	$110 Copay	OON Deductible & Coinsurance	$110 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	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**	$20 Copay	OON Deductible & Coinsurance	$20 Copay	OON Deductible & Coinsurance	$20 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs	$180 Copay	OON Deductible & Coinsurance	$180 Copay	OON Deductible & Coinsurance	$180 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs	$220 Copay	OON Deductible & Coinsurance	$220 Copay	OON Deductible & Coinsurance	$220 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	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	1-877-635-9545
Website	https://secure.proactrx.com/
Pharmacy Advantage Formulary	Pharmacy Advantage Formulary
Telehealth and Mail Order Formulary	Telehealth and Mail Order Formulary
Pharmacy Exclusions	Pharmacy Exclusions

Plan Comparison: Summary of Benefits & Coverage

PREMIUMS BY AGE BAND									
PLAN	**MM $1,000**			**MM $2,500**			**MM $3,500**		
NETWORK	**PHCS**	**CIGNA**	**ANTHEM**	**PHCS**	**CIGNA**	**ANTHEM**	**PHCS**	**CIGNA**	**ANTHEM**
AGES 18-29									
Employee	$794.78	$854.78	$874.78	$689.25	$749.25	$769.25	$622.11	$682.11	$702.11
Employee + Spouse	$1,407.81	$1,487.81	$1,507.81	$1,203.11	$1,283.11	$1,303.11	$1,072.86	$1,152.86	$1,172.86
Employee + Child(ren)	$1,295.61	$1,375.61	$1,395.61	$1,109.46	$1,189.46	$1,209.46	$991.03	$1,071.03	$1,091.03
Family	$2,028.45	$2,128.45	$2,148.45	$1,724.53	$1,824.53	$1,844.53	$1,531.17	$1,631.17	$1,651.17
AGES 30-44									
Employee	$820.64	$880.64	$900.64	$710.89	$770.89	$790.89	$666.07	$726.07	$746.07
Employee + Spouse	$1,457.99	$1,537.99	$1,557.99	$1,245.09	$1,325.09	$1,345.09	$1,189.00	$1,269.00	$1,289.00
Employee + Child(ren)	$1,341.23	$1,421.23	$1,441.23	$1,171.06	$1,251.06	$1,271.06	$1,089.00	$1,169.00	$1,189.00
Family	$2,102.93	$2,202.93	$2,222.93	$1,786.86	$1,886.86	$1,906.86	$1,627.00	$1,727.00	$1,747.00
AGES 45-54									
Employee	$857.89	$917.89	$937.89	$742.88	$802.88	$822.88	$694.00	$754.00	$774.00
Employee + Spouse	$1,525.42	$1,605.42	$1,625.42	$1,302.31	$1,382.31	$1,402.31	$1,211.00	$1,291.00	$1,311.00
Employee + Child(ren)	$1,403.03	$1,483.03	$1,503.03	$1,224.64	$1,304.64	$1,324.64	$1,119.00	$1,199.00	$1,219.00
Family	$2,200.63	$2,300.63	$2,320.63	$1,869.41	$1,969.41	$1,989.41	$1,689.00	$1,789.00	$1,809.00
AGES 55-64									
Employee	$950.20	$1,010.20	$1,030.20	$819.31	$879.31	$899.31	$739.00	$799.00	$819.00
Employee + Spouse	$1,709.34	$1,789.34	$1,809.34	$1,455.41	$1,535.41	$1,555.41	$1,289.00	$1,369.00	$1,389.00
Employee + Child(ren)	$1,569.76	$1,649.76	$1,669.76	$1,338.88	$1,418.88	$1,438.88	$1,191.00	$1,271.00	$1,291.00
Family	$2,476.05	$2,576.05	$2,596.05	$2,099.09	$2,199.09	$2,219.09	$1,824.00	$1,924.00	$1,944.00