

LIFEX RESEARCH CORP

Summary of Benefits & Coverage

MM $7,250 Deductible

Rates effective as of January 1, 2027
PPO In-Network

Network Options:

PHCS or MAGNACARE

MAGNACARE IS ONLY AVAILABLE IN **NEW YORK** AND **NEW JERSEY

Summary of Benefits & Coverage

NETWORK	INN	OON
Payment for Services		
In-network Provider: The provider network is shown on your I.D. card. Locating in-network providers: MagnaCare, PHCS		
Maximum Annual Benefit	UNLIMITED	
Deductible (The amount the Covered Person pays each plan year for Covered Services before the Coinsurance is payable.) • Individual • Family	$7,250 $14,500	$14,500 $29,000
Deductibles and Out-of-pocket Limits for In-network and Out-of-network services are separate and do not cross-accumulate, except as required by the No Surprises Act.		
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	$12,000 $24,000	$24,000 $48,000
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 Preventive Screenings	• 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 Eye Exam • Biofeedback	• Children's Glasses
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 $750), 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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NETWORK	INN	OON
Covered Services - Illness or Injury		

Physician Office Services
• Primary Care Physician
• Specialist Office Visit
  ◦ No referral needed
• Urgent Care Visit
• Chiropractic Care
  ◦ 24 visits per plan year
	$50 Copay
	$75 Copay
	$125 Copay
	$60 Copay
		OON Deductible & Coinsurance

Surgery Performed in the Office	20% After Deductible	OON Deductible & Coinsurance
Telemedicine- Through OurLiveDoc ONLY Primary and Urgent Care Call: 940-LIVE-DOC (940-548-3362) to get started Behavioral Health	$0 Copay $0 Copay	Not Covered
Labs - Independent / In Office	$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
Therapies: Physical, Speech, Occupational, Cardiac, & Respiratory 30 visits per plan year combined	$60 Copay	OON Deductible & Coinsurance
Therapies: ABA, TMS 24 visits per plan year combined	$60 Copay	OON Deductible & Coinsurance
Emergency (No Precertification Needed but Notify TPAX Within 48 hours or 1 business day)		
Emergency Room Care Processed according to No Surprise Act (NSA) standards.	20% After Deductible	See In Network
Ambulance	20% After Deductible	See In Network
Inpatient Hospital Services (Precertification Required)		
Inpatient Hospital Care Facility	20% After Deductible	OON Deductible & Coinsurance
Inpatient Hospital Surgical Services	20% After Deductible	OON Deductible & Coinsurance
Associated/Incidental Inpatient Services (Anesthesia, Pathology, Physician Services, and any other incurred services)	20% After Deductible	OON Deductible & Coinsurance
Mental Health / Substance Use Disorder Partial Hospitalization (PHP)/ Intensive Outpatient Program (IOP)	20% After Deductible	OON Deductible & Coinsurance
Mental Health / Substance Use Disorder – Inpatient Facility (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
Mental Health / Substance Use Disorder – Residential Treatment. 30 days per plan year (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
Mental Health / Substance Use Disorder – Outpatient and Office Visits	20% After Deductible	OON Deductible & Coinsurance

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NETWORK	INN	OON
Inpatient Skilled Nursing Facility 30 days per plan year	20% After Deductible	OON Deductible & Coinsurance
Inpatient Rehabilitation Facility 30 days per plan year	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered
Inpatient Hospice 30 days per lifetime maximum	20% After Deductible	OON Deductible & Coinsurance
Preventive Services - Click here for a complete list.		
Preventive Care See Preventive Care Guide	$0 Copay	OON Deductible & Coinsurance
Outpatient Facility Services (Precertification Required)		
Outpatient Surgical Facility Services	20% After Deductible	OON Deductible & Coinsurance
Surgeon	20% After Deductible	OON Deductible & Coinsurance
Associated Surgery Services (Anesthesia and any other incurred services associated with outpatient surgery)	20% After Deductible	OON Deductible & Coinsurance
Outpatient Chemotherapy and Radiotherapy 30 days per plan year	20% After Deductible	Not Covered
Infusion/Injection Subject to 90 day waiting period	20% After Deductible	OON Deductible & Coinsurance
Dialysis Limited to acute temporary dialysis	20% After Deductible	Not Covered
Outpatient Hospital Labs No precertification Required	20% After Deductible	OON Deductible & Coinsurance
Observation	20% After Deductible	OON Deductible & Coinsurance
Maternity Services		
Routine Prenatal/Postnatal Office Visits	$0 Copay	OON Deductible & Coinsurance
Delivery	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services		
Home Health Care Visits (Precertification Required). 60 visits per plan year	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (Precertification Required for items $750 and up)	20% After Deductible	OON Deductible & Coinsurance
Nutritional Counseling 1 visit per plan year	$0 Copay Deductible Does Not Apply	OON Deductible & Coinsurance
Prosthetics (Precertification Required) 1 item per plan year. Prosthetic replacement subject to 12 month waiting period.	20% After Deductible	OON Deductible & Coinsurance
Allergy Testing/Injections	20% After Deductible	OON Deductible & Coinsurance
All Other Covered Services	20% After Deductible	OON Deductible & Coinsurance

Summary of Benefits & Coverage

NETWORK		INN	OON
Prescription Drugs			
Retail Pharmacy Copayments See Formulary	**Preventive Medicine**	$0 Copay	OON Deductible & Coinsurance
	Generic Drugs (See Formulary) 30 day-supply at retail for urgent care drugs	$10 Copay	OON Deductible & Coinsurance
	Generic Drugs (See Formulary) 30 day-supply maintenance medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$10 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs (See Formulary) 30 day-supply at retail for urgent care drugs	$90 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs (See Formulary) 30 day-supply maintenance medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$90 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs (See Formulary) 30 day-supply at retail for urgent care drugs	$110 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs (See Formulary) 30 day-supply maintenance medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$110 Copay	OON Deductible & Coinsurance
	GLP1 Medication (for qualifying members, not covered for weight loss) 30 day-supply maintenance medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$200 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments See Formulary	**Generic Drugs** (See Formulary) 90 day-supply	$20 Copay	OON Deductible & Coinsurance
	Preferred Brand Name Drugs (See Formulary) 90 day-supply	$180 Copay	OON Deductible & Coinsurance
	Non-Preferred Brand Name Drugs (See Formulary) 90 day-supply	$220 Copay	OON Deductible & Coinsurance
	GLP1 Medication (for qualifying members, not covered for weight loss) 90 day-supply	$600 Copay	OON Deductible & Coinsurance
	Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available
RX Benefit Highlights			
RX Company		ProAct	
Phone		1-888-250-8032	
Website		https://secure.proactrx.com/	
Pharmacy Advantage 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. This penalty does not apply to Emergency Services.
2. Elective Surgery/Procedures/Injections will not be covered for the first 90 days of coverage. This 90-day limitation does not apply to preventive services required under the Affordable Care Act (see the Preventive Care Guide), to Emergency Services, or to any service for which applying it would violate applicable law.
3. If you have an emergency medical condition, you may go to the nearest emergency room, whether in or out of network. Emergency services are covered at the in-network cost-sharing level.
4. Emergency Services never require precertification or prior authorization. If you are admitted as an inpatient following Emergency Services, please notify TPAX within 48 hours of admission or by the next business day so that TPAX can coordinate your care. Failure to give this notice will not reduce benefits, result in a penalty, or cause a denial.
5. Deductibles and Out-of-pocket Limits for In-network and Out-of-network services are separate and do not cross-accumulate, except as required by the No Surprises Act.
6. Out-of-network pharmacy: you pay the full price at the pharmacy and submit a claim. The Plan reimburses the Allowable Charge, less the Out-of-network Deductible and Coinsurance shown above. You are responsible for any amount above the Allowable Charge. See “Prescription Drug Program Management.”

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MM $7,250 Deductible

PREMIUMS BY AGE BAND	
AGES 18-29	
Employee	$542.00
Employee + Spouse	$932.00
Employee + Child(ren)	$856.00
Family	$1,329.00
AGES 30-44	
Employee	$557.00
Employee + Spouse	$962.00
Employee + Child(ren)	$883.00
Family	$1,374.00
AGES 45-54	
Employee	$582.00
Employee + Spouse	$1,006.00
Employee + Child(ren)	$924.00
Family	$1,437.00
AGES 55-64	
Employee	$615.00
Employee + Spouse	$1,079.00
Employee + Child(ren)	$988.00
Family	$1,548.00