

LIFEX RESEARCH CORP

Summary of Benefits & Coverage

$500/$1,000 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

Professional Services	In-Network Benefits	Out-Of-Network What Member Pays
In-network Provider: The provider network is shown on your I.D. card. Locating in-network providers: MagnaCare, PHCS		***OON coverage is covered as deductible met, then a copay + 15% coinsurance
Deductible • Individual • Family	$500 $1,000	$1,000 $2,000
Out-of-Pocket Maximum - Including Deductible, Copay, Coinsurance, and Rx. • Individual • Family (Embedded)	$12,000 $24,000	$24,000 $48,000
Lifetime Maximum	Unlimited	Unlimited
PCP Office Visit	$50 Copay After Deductible	$50 Copay + 15% After Deductible
Specialist Office Visit (Includes behavioral health office visits)	$75 Copay After Deductible	$75 Copay + 15% After Deductible
Urgent Care Office Visit	$100 Copay After Deductible	$100 Copay + 15% After Deductible
Surgery Performed in the Office	See Outpatient Surgery	See Outpatient Surgery
Chiropractic Care 12 visits per plan year maximum	$75 Copay After Deductible	$75 Copay + 15% After Deductible
Therapies: Physical, Speech, Occupational, Cardiac & Respiratory 16 visits per plan year maximum combined	$75 Copay/Visit After Deductible	$75 Copay + 15% After Deductible
Therapies: ABA & TMS 16 visits per plan year maximum	$75 Copay/Visit After Deductible	$75 Copay + 15% After Deductible
Labs (Independent Lab Only)	$50 Copay (Deductible Does Not Apply)	$50 Copay + 15% (Deductible Does Not Apply)
Imaging (Stand Alone Radiology Only)	$100 Copay (Deductible Does Not Apply)	$100 Copay + 15% (Deductible Does Not Apply)
Diagnostic Testing/Advanced Imaging (Pre-certification Required)	$500 Copay After Deductible	$500 Copay + 15% After Deductible
Telemedicine through OurLiveDoc ONLY **Primary and Urgent Care, Behavioral Health** Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay	Not Covered
Emergency (No Precertification Needed but Notify TPAX Within 48 hours or 1 business day)	Participating Provider	Non-Participating Provider
Emergency Room Care Processed according to No Surprise Act (NSA) standards.	$1,000 Copay After Deductible	See in Network
Ambulance - Land **Ambulance** - Air (2 per plan year combined) Processed according to No Surprise Act (NSA) standards.	$500 Copay After Deductible $1,000 Copay After Deductible	See in Network
Inpatient or Partial Hospitalization Services (Precertification Required)	Participating Provider	Non-Participating Provider
Inpatient Hospital Care Facility	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 15% After Deductible
Inpatient Surgical Services	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 15% After Deductible
Associated/Incidental Inpatient Services (Anesthesia, Pathology, Physician Services, and any other incurred services)	$250 Copay/Service After Deductible	$250 Copay/Service + 15% After Deductible
Inpatient Skilled Nursing Facility 21 day limit per plan year	$125 Copay/Day After Deductible	$125 Copay/Day + 15% After Deductible
Inpatient Rehabilitation Facility 14 day limit per plan year	$125 Copay/Day After Deductible	$125 Copay/Day + 15% After Deductible
Hospice 30 day limit per lifetime	$0 Copay After Deductible	$0 Copay + 15% After Deductible
Organ Transplant	$2,500 Copay/Admission After Deductible	$2,500 Copay/Admission + 15% After Deductible

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Mental Health / Substance Use Disorder **Partial Hospitalization (PHP)/ Intensive Outpatient Program (IOP)**	$2,500 Copay/Week After Deductible	$2,500 Copay/Week + 15% After Deductible
Mental Health / Substance Use Disorder – Inpatient Facility (Precertification Required)	See Inpatient Hospital Care Facility	See Inpatient Hospital Care Facility
Mental Health / Substance Use Disorder – Residential Treatment 21-day limit per plan year (Precertification Required)	$125 Copay/Day After Deductible	$125 Copay/Day + 15% After Deductible
Mental Health / Substance Use Disorder – Outpatient and Office Visits	$75 Copay After Deductible	$75 Copay + 15% After Deductible
Outpatient Services (Precertification Required)	Participating Provider	Non-Participating Provider
Outpatient Surgical Services (Outpatient Hospital, Surgery Center or Office)	$2,500 Copay/Surgery After Deductible	$2,500 Copay/Surgery + 15% After Deductible
Surgeon	$1,000 Copay/Surgery After Deductible	$1,000 Copay/Surgery + 15% After Deductible
Associated Surgery Services (Anesthesia and any other incurred services associated with outpatient surgery)	$250 Copay/Service After Deductible	$250 Copay/Service + 15% After Deductible
Outpatient Chemotherapy and Radiotherapy	$500 Copay/Visit After Deductible	$500 Copay/Visit + 15% After Deductible
Infusion / Injection	$500 Copay/Visit After Deductible	$500 Copay/Visit + 15% After Deductible
Dialysis	$500 Copay/Visit After Deductible	$500 Copay/Visit + 15% After Deductible
Outpatient Hospital Labs (No precertification Required)	$100 Copay After Deductible	$100 Copay + 15% After Deductible
Observation	$1,500 Copay After Deductible	$1,500 Copay + 15% After Deductible
Preventive Services	Participating Provider	Non-Participating Provider
Preventive Care See Preventive Care Guide	$0 Copay	35% Coinsurance
Maternity Services	Participating Provider	Non-Participating Provider
Pregnancy, Maternity - Delivery **All Other Routine Maternity Service** (Including office visits, lab work, radiology, prenatal/postnatal care, etc. Excludes Genetic testing.)	$2,500 Copay At Delivery After Deductible $0 Copay	$2,500 Copay + 15% At Delivery After Deductible 15% Coinsurance After Deductible
Other Covered Services	Participating Provider	Non-Participating Provider
Home Health Care Visits (Pre-certification Required) 10 visits per plan year	$75 Copay/Visit After Deductible	$75 Copay/Visit + 15% After Deductible
Durable Medical Equipment (DME) (Precertification Required for items $750 and Up) Copayment is applied per item received. 5 items / plan year.	$125 Copay/Item After Deductible	$125 Copay/Item + 15% After Deductible
Nutritional Counseling (1 visit per plan year)	$0 Copay	15% Coinsurance
Prosthetics (Pre-certification Required) 1 item per plan year. Prosthetic replacement subject to 12 month waiting period.	$500 Copay/Item After Deductible	$500 Copay/Item + 15% After Deductible
Allergies Shots/Serums Visits/Testing	$50 Copay After Deductible $75 Copay/Visit After Deductible	$50 Copay + 15% After Deductible $75 Copay/Visit + 15% After Deductible

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All Other Covered Services	20% After Deductible		35% After Deductible
Prescription Drugs	Participating Provider		Non-Participating Provider
Retail Pharmacy Copayments See Formulary	**Preventive Medicine Rx - Generic or Brand** (See Formulary)	$0 Copay	15% Coinsurance After Deductible
	Generic Drugs – Urgent Care Rx (See Formulary) 30 day-supply at retail pharmacies.	$0 Copay	15% Coinsurance After Deductible
	Generic Drugs - Maintenance Rx (See Formulary) 30 day-supply at retail pharmacies. Mail order required for maintenance medication after initial 30 day-supply.	$0 Copay	15% Coinsurance After Deductible
	Preferred Brand Name Drugs	PAP Available	Not Covered
	Non-Preferred Brand Name Drugs	PAP Available	Not Covered
	Specialty Drugs	PAP Available	Not Covered
Mail Order or Retail Pharmacy Copayments See Formulary	**Generic Drugs** (See Formulary) 90 day-supply maintenance medication	$0 Copay	15% Coinsurance After Deductible
	Preferred Brand Name Drugs	Patient Assistance Plans Available	Not Covered
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available	Not Covered
	Specialty Drugs	Patient Assistance Plans Available	Not Covered
Rx Benefit Highlights			
Rx Company	ProAct		
Phone 24/7/365	1-888-250-8032		
Website	https://secure.proactrx.com/		
Formulary	Formulary		
Mail Order/Telehealth	Mail Order/Telehealth		

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. Copayments, Coinsurance, Deductibles, and prescription drug cost-sharing (other than amounts excluded under “Out-of-pocket Limit”) count toward the Out-of-pocket Limit.
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 15% Coinsurance (after Deductible) shown above. You are responsible for any amount above the Allowable Charge. See “Prescription Drug Program Management.”

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PREMIUMS BY AGE BAND	
AGES 18-29	
Employee	$451.00
Employee + Spouse	$829.00
Employee + Child(ren)	$818.00
Family	$1,112.00
AGES 30-44	
Employee	$514.00
Employee + Spouse	$871.00
Employee + Child(ren)	$860.00
Family	$1,175.00
AGES 45-54	
Employee	$545.00
Employee + Spouse	$913.00
Employee + Child(ren)	$902.00
Family	$1,228.00
AGES 55-64	
Employee	$598.00
Employee + Spouse	$934.00
Employee + Child(ren)	$913.00
Family	$1,270.00