



Health Benefits 2.0

COMPREHENSIVE MAJOR MEDICAL PLANS

Plan	IHP Ultimate (RBP)	IHP Ultimate (PPO)	IHP Ultimate \$5K (RBP)	IHP Ultimate \$5K (PPO)
Network	PHCS / Multiplan	PHCS or Cigna ²	PHCS / Multiplan	PHCS or Cigna ²
Deductible (Indv/Fam)	\$0 / \$0	\$0 / \$0	\$5,000 / \$10,000	\$5,000 / \$10,000
Maximum Out of Pocket (Indv/Fam)	\$2,000 / \$13,200	\$2,000 / \$13,200	\$7,000 / \$14,000	\$7,000 / \$14,000
Preventive, Physician & Diagnostic Services				
Preventive & Wellness (Non-Hospital Based)	Included	Included	Included	Included
Primary Care Office Visit (Non-Hospital Based)	\$20 Copay	\$20 Copay	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
Specialist Office Visit (Non-Hospital Based) (Includes Mental and Behavioral Health)	\$40 Copay	\$40 Copay	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
Urgent Care	\$50 Copay	\$50 Copay	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
Telemedicine	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)
Laboratory Services & Radiology (Non-Hospital Based)	\$50 Copay	\$50 Copay	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
CT / MRI / MRA / PET Scan (Non-Hospital Based) (Prior Authorization Required)	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Allergy Services	\$40 Copay (Separate copay from PCP or Specialist Office visit.)	\$40 Copay (Separate copay from PCP or Specialist Office visit.)	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
Hospital & Facility Services (Subject to Referenced Based Pricing, except for PPO plans)				
Inpatient Hospitalization (Prior Authorization Required)	\$400 Copay per Admission ¹	\$400 Copay per Admission	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Inpatient Visits - Physician	Included in IP Hospitalization Copay	Included in IP Hospitalization Copay	Included in IP Hospitalization Benefit	Included in IP Hospitalization Benefit
Inpatient Surgery (Prior Authorization Required)	Included in IP Hospitalization Copay	Included in IP Hospitalization Copay	Included in IP Hospitalization Benefit	Included in IP Hospitalization Benefit
Outpatient Hospital or Free-Standing Facility Services and Surgery (Prior Authorization Required)	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Anesthesia	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Benefit	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Benefit
Emergency Room	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Ambulance Service (Ground Services Only)	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Second Surgical Opinion	\$0 Copay	\$0 Copay	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
Pregnancy Benefits				
Professional Services	\$50 Copay	\$50 Copay	After Deductible, Plan pays 100%	After Deductible, Plan pays 100%
Maternity / Childbirth / Delivery (Considered Inpatient Hospital Stay) (Prior Authorization Required)	\$400 Copay per Admission ¹	\$400 Copay per Admission	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%

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Other Services				
Home Health Care <i>(Prior Authorization Required)</i>	\$25 Copay <i>(20 visits per plan year)</i>	\$25 Copay <i>(20 visits per plan year)</i>	After Deductible, Plan pays 100% <i>(20 visits per plan year)</i>	After Deductible, Plan pays 100% <i>(20 visits per plan year)</i>
Hospice <i>(Prior Authorization Required)</i>	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Treatment for Chemical Abuse & Dependency – Inpatient <i>(Prior Authorization Required)</i>	\$250 Copay per Day ¹ <i>(10 days per plan year)</i>	\$250 Copay per Day <i>(10 days per plan year)</i>	After Deductible, benefit subject to RBP <i>(10 days per plan year)</i>	After Deductible, Plan pays 100% <i>(10 days per plan year)</i>
Treatment for Chemical Abuse & Dependency – Outpatient <i>(Prior Authorization Required)</i>	\$25 Copay per Day <i>(10 days per plan year)</i>	\$25 Copay per Day <i>(10 days per plan year)</i>	After Deductible, Plan pays 100% <i>(10 days per plan year)</i>	After Deductible, Plan pays 100% <i>(10 days per plan year)</i>
Chemotherapy / Radiation Therapy <i>(Prior Authorization Required)</i> <i>(Chemotherapy only includes infusion, not oral)</i>	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Dialysis <i>(Prior Authorization Required)</i>	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Rehabilitation / Habilitation Services <i>(Physical, Speech, and Occupational)</i> <i>(Prior Authorization Required)</i>	\$75 Copay per Day <i>(20 visits per plan year)</i>	\$75 Copay per Day <i>(20 visits per plan year)</i>	After Deductible, Plan pays 100% <i>(20 visits per plan year)</i>	After Deductible, Plan pays 100% <i>(20 visits per plan year)</i>
Transplant – Facility <i>(Prior Authorization Required)</i>	\$400 Copay ¹	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Transplant – Physician & Anesthesiologist Charges during Inpatient Hospitalization <i>(Prior Authorization Required)</i>	Benefit Subject to Reference Based Pricing	\$400 Copay	After Deductible, benefit subject to RBP	After Deductible, Plan pays 100%
Pharmacy Benefits (Subject to Formulary)				
Preventive <i>(Generic Only)</i>	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Non-Preventive <i>(Retail)</i>	\$5 Copay <i>(APS Acute List)</i> \$10 Copay <i>(All Other Generic)</i> \$40 Copay <i>(Preferred Brand)</i> \$80 Copay <i>(Non-Preferred Brand)</i>	\$5 Copay <i>(APS Acute List)</i> \$10 Copay <i>(All Other Generic)</i> \$40 Copay <i>(Preferred Brand)</i> \$80 Copay <i>(Non-Preferred Brand)</i>	After Deductible, \$5 Copay <i>(APS Acute List)</i> \$10 Copay <i>(All Other Generic)</i> \$40 Copay <i>(Preferred Brand)</i> \$80 Copay <i>(Non-Preferred Brand)</i>	After Deductible, \$5 Copay <i>(APS Acute List)</i> \$10 Copay <i>(All Other Generic)</i> \$40 Copay <i>(Preferred Brand)</i> \$80 Copay <i>(Non-Preferred Brand)</i>
Non-Preventive <i>(Mail Order)</i>	\$15 Copay <i>(APS Chronic List)</i> \$30 Copay <i>(All Other Generic)</i> \$120 Copay <i>(Preferred Brand)</i> \$240 Copay <i>(Non-Preferred Brand)</i>	\$15 Copay <i>(APS Chronic List)</i> \$30 Copay <i>(All Other Generic)</i> \$120 Copay <i>(Preferred Brand)</i> \$240 Copay <i>(Non-Preferred Brand)</i>	After Deductible, \$15 Copay <i>(APS Chronic List)</i> \$30 Copay <i>(All Other Generic)</i> \$120 Copay <i>(Preferred Brand)</i> \$240 Copay <i>(Non-Preferred Brand)</i>	After Deductible, \$15 Copay <i>(APS Chronic List)</i> \$30 Copay <i>(All Other Generic)</i> \$120 Copay <i>(Preferred Brand)</i> \$240 Copay <i>(Non-Preferred Brand)</i>
<p>¹ After Copay, benefit subject to Reference Based Pricing</p> <p>² PHCS will be the network for any groups with less than 25 enrolled employees in the PPO plan(s) being offered. Cigna will be the network for any groups with 25 or more enrolled employees in the PPO plan(s) being offered.</p>				

Rates

Plan	IHP Ultimate (RBP)	IHP Ultimate (PPO)	IHP Ultimate \$5K (RBP)	IHP Ultimate \$5K (PPO)
Single	\$556.84	\$729.60	\$510.16	\$697.19
EE + Spouse	\$981.43	\$1,334.48	\$894.32	\$1,208.19
EE + Child(ren)	\$839.90	\$1,132.85	\$766.27	\$1,029.52
Family	\$1,264.51	\$1,712.76	\$1,150.45	\$1,565.54

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