Health Benefits 2.0

LIMITED ACCESS MAJOR MEDICAL PLANS

Plan	IHP Plus	IHP Premier
Network	PHCS / Multiplan	PHCS / Multiplan
Deductible *(Indv/Fam)*	$0 / $0	$0 / $0
Maximum Out of Pocket *(Indv/Fam)*	$5,000 / $10,000	$5,000 / $10,000
Preventive, Physician & Diagnostic Services		
Preventive & Wellness *(Non-Hospital Based)*	Included	Included
Primary Care Office Visit *(Non-Hospital Based)*	$15 Copay *(10 visits per plan year)*	$15 Copay *(12 visits per plan year)*
Specialist Office Visit *(Non-Hospital Based) (Includes Mental and Behavioral Health)*	$25 Copay *(10 visits per plan year)*	$25 Copay *(12 visits per plan year)*
Urgent Care	$35 Copay *(3 visits per plan year)*	$35 Copay *(3 visits per plan year)*
Telemedicine	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited)*
Laboratory Services & Radiology *(Non-Hospital Based)*	$50 Copay *(3 visits per plan year)*	$50 Copay *(4 visits per plan year)*
CT / MRI / MRA / PET Scan *(Non-Hospital Based) (Prior Authorization Required)*	$350 Copay[1] *(2 per plan year)*	$350 Copay[1] *(3 per plan year)*
Allergy Services	$25 Copay *(Included in PCP or Specialist Office visit limits but separate copay.)*	$25 Copay *(Included in PCP or Specialist Office visit limits but separate copay.)*
Hospital & Facility Services (Subject to Referenced Based Pricing)		
Inpatient Hospitalization *(Prior Authorization Required)*	$350 Copay per Admission[1] *(7 days per plan year)*	$350 Copay per Admission[1] *(10 days per plan year)*
Inpatient Visits - Physician	Included in IP Hospitalization Copay	Included in IP Hospitalization Copay
Inpatient Surgery *(Prior Authorization Required)*	Included in IP Hospitalization Copay *(3 surgeries per plan year)*	Included in IP Hospitalization Copay *(4 surgeries per plan year)*
Outpatient Hospital or Free-Standing Facility Services and Surgery *(Prior Authorization Required)*	$350 Copay[1] *(2 visits per plan year)*	$350 Copay[1] *(2 visits per plan year)*
Anesthesia	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay *(3 IP and 2 OP per plan year)*	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay *(4 IP and 2 OP per plan year)*
Emergency Room	$350 Copay[1] *(1 visit per plan year)*	$350 Copay[1] *(2 visits per plan year)*
Ambulance Service *(Ground Services Only)*	$250 Copay[1] *(1 per plan year)*	$250 Copay[1] *(2 per plan year)*
Second Surgical Opinion	$0 Copay	$0 Copay
Pregnancy Benefits		
Professional Services	$350 Copay	$350 Copay
Maternity / Childbirth / Delivery *(Considered Inpatient Hospital Stay) (Prior Authorization Required)*	$350 Copay per Admission[1]	$350 Copay per Admission[1]
Other Services		
Home Health Care *(Prior Authorization Required)*	$25 Copay *(15 visits per plan year)*	$25 Copay *(20 visits per plan year)*
Hospice *(Prior Authorization Required)*	Not Covered	Not Covered
Treatment for Chemical Abuse & Dependency – Inpatient *(Prior Authorization Required)*	$250 Copay per Day[1] *(7 days per plan year)*	$250 Copay per Day[1] *(10 days per plan year)*
Treatment for Chemical Abuse & Dependency – Outpatient *(Prior Authorization Required)*	$25 Copay per Day *(7 days per plan year)*	$25 Copay per Day *(10 days per plan year)*
Chemotherapy / Radiation Therapy *(Prior Authorization Required) (Chemotherapy only includes infusion, not oral)*	Not Covered	Not Covered
Dialysis *(Prior Authorization Required)*	Not Covered	Not Covered
Rehabilitation / Habilitation Services *(Physical, Speech, and Occupational) (Prior Authorization Required)*	Not Covered	$50 Copay per Day *(12 visits per plan year)*
Transplant – Facility *(Prior Authorization Required)*	Not Covered	Not Covered
Transplant – Physician & Anesthesiologist Charges during Inpatient Hospitalization *(Prior Authorization Required)*	Not Covered	Not Covered

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Steven.Chapkin@aafd.org | aafd.org/HealthBenefits

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Pharmacy Benefits (Subject to Formulary)		
Preventive *(Generic Only)*	$0 Copay	$0 Copay
Non-Preventive *(Retail)*	$5 Copay *(APS Acute List)* $10 Copay *(All Other Generic)* $40 Copay *(Preferred Brand)* $80 Copay *(Non-Preferred Brand)*	$5 Copay *(APS Acute List)* $10 Copay *(All Other Generic)* $40 Copay *(Preferred Brand)* $80 Copay *(Non-Preferred Brand)*
Non-Preventive *(Mail Order)*	$15 Copay *(APS Chronic List)* $30 Copay *(All Other Generic)* $120 Copay *(Preferred Brand)* $240 Copay *(Non-Preferred Brand)*	$15 Copay *(APS Chronic List)* $30 Copay *(All Other Generic)* $120 Copay *(Preferred Brand)* $240 Copay *(Non-Preferred Brand)*

[1] After Copay, benefit subject to Reference Based Pricing

* Plus and Premium plans have annual day or visit limits

Rates

Plan	IHP Plus	IHP Premier
Single	$435.94	$469.01
EE + Spouse	$715.46	$770.23
EE + Child(ren)	$627.29	$669.82
Family	$906.81	$971.04

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