MVP Options

PLAN	IHP CORE *(Formerly IHP Basic)*	IHP CHOICE *(Formerly IHP Plus)*	IHP PRIME *(Formerly IHP Premier)*
Network	PHCS	PHCS	PHCS
Deductible *(Individual/Family)*	$0/$0	$0/$0	$0/$0
Maximum Out of Pocket *(Individual/Family)*	$9,100/$18,200	$9,100/$18,200	$9,100/$18,200
Preventive Care			
Routine Well Care *(Non-Hospital Services)*	Included	Included	Included
Routine Well Care *(Hospital Services)*	Not covered	Not covered	Not covered
Physician Services			
Primary Care Office Visit *(Includes mental and behavioral health)*	$25 Copay *(8 visits per Plan Year)*	$25 Copay *(10 visits per Plan Year)*	$25 Copay *(12 visits per Plan Year)*
Specialist Office Visit	$50 Copay *(8 visits per Plan Year)*	$50 Copay *(10 visits per Plan Year)*	$50 Copay *(12 visits per Plan Year)*
Allergy Services *(Copay applies to the administration of the allergy service and is separate from the Copay for the office visit)*	$50 Copay	$50 Copay	$50 Copay
Other Services Performed in Physician Office	$50 Copay	$50 Copay	$50 Copay
Telemedicine	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited)*
Urgent Care	$75 Copay *(2 visits per Plan Year)*	$75 Copay *(3 visits per Plan Year)*	$75 Copay *(3 visits per Plan Year)*
Diagnostic Testing (Subject to RBP – Except for Laboratory Services)			
Radiology & Advanced Imaging *(When utilizing Medmo)*	$0 Copay *(3 visits combined per Plan Year for Lab & Radiology, 1 test combined per Plan Year for Advanced Imaging)*	$0 Copay *(3 visits combined per Plan Year for Lab & Radiology, 2 tests combined per Plan Year for Advanced Imaging)*	$0 Copay *(4 visits combined per Plan Year for Lab & Radiology, 3 tests combined per Plan Year for Advanced Imaging)*
Radiology *(Non-Hospital Services) (Outside Medmo)*	$50 Copay *(3 visits combined per Plan Year for Lab & Radiology)*	$50 Copay *(3 visits combined per Plan Year for Lab & Radiology)*	$50 Copay *(4 visits combined per Plan Year for Lab & Radiology)*
Advanced Imaging *(Non-Hospital Services) (Outside Medmo)*	$350 Copay *(1 test combined per Plan Year for Advanced Imaging)*	$350 Copay *(2 tests combined per Plan Year for Advanced Imaging)*	$350 Copay *(3 tests combined per Plan Year for Advanced Imaging)*
Laboratory *(Non-Hospital Services)*	$50 Copay *(3 visits combined per Plan Year for Lab & Radiology)*	$50 Copay *(3 visits combined per Plan Year for Lab & Radiology)*	$50 Copay *(4 visits combined per Plan Year for Lab & Radiology)*
Laboratory, Radiology & Advanced Imaging *(Hospital Services)*	Not covered	Not covered	Not covered
Hospital, Emergency & Facility Services (Subject to RBP)			
Ambulance *(Ground Only)*	$500 Copay *(1 transport per Plan Year)*	$500 Copay *(1 transport per Plan Year)*	$500 Copay *(2 transports per Plan Year)*
Emergency	$750 Copay *(1 visit per Plan Year)*	$750 Copay *(1 visit per Plan Year)*	$750 Copay *(2 visits per Plan Year)*
Non-Emergency	Not covered	Not covered	Not covered
Inpatient Facility *(Pre-authorization required)*	$750 Copay/per admission *(5 days per Plan Year, 2 Inpatient anesthetic procedures per Plan Year)*	$750 Copay/per admission *(7 days per Plan Year, 3 Inpatient anesthetic procedures per Plan Year)*	$750 Copay/per admission *(10 days per Plan Year, 4 Inpatient anesthetic procedures per Plan Year)*
NICU	Not covered	$750 Copay/per admission *(7 days per Plan Year, combined with inpatient facility day limits)*	$750 Copay/per admission *(10 days per Plan Year, combined with inpatient facility day limits)*
Outpatient Services or Surgery *(Pre-authorization required)*	$350 Copay *(1 visit per Plan Year)*	$350 Copay *(2 visits combined per Plan Year, 2 outpatient anesthetic procedures combined per Plan Year)*	$350 Copay *(2 visits combined per Plan Year, 2 outpatient anesthetic procedures combined per Plan Year)*
Ambulatory Surgical or Outpatient Surgical Facility *(Pre-authorization required)*	$350 Copay *(1 visit per Plan Year)*	$350 Copay *(2 visits combined per Plan Year, 2 outpatient anesthetic procedures combined per Plan Year)*	$350 Copay *(2 visits combined per Plan Year, 2 outpatient anesthetic procedures combined per Plan Year)*
Second Surgical Opinion *(Must utilize VezaHealth)*	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited)*
Maternity Services (Subject to RBP)			
Inpatient Facility *(Copay is in addition to the inpatient Copay)*	Not covered	$750 Copay/per admission	$750 Copay/per admission
Professional Services	Not covered	$350 Copay	$350 Copay
Mental or Nervous Disorders or Substance Abuse Treatment (Subject to RBP)			
Inpatient Facility *(Preauthorization required)*	$750 Copay/per admission *(5 days per Plan Year)*	$750 Copay/per admission *(7 days per Plan Year)*	$750 Copay/per admission *(10 days per Plan Year)*
Outpatient Facility *(Preauthorization required)*	$350 Copay *(8 days per Plan Year)*	$350 Copay *(10 days per Plan Year)*	$350 Copay *(12 days per Plan Year)*
Other Services			
Chiropractic Care	$75 Copay *(8 visits per Plan Year)*	$75 Copay *(10 visits per Plan Year)*	$75 Copay *(10 visits per Plan Year)*
Speech Therapy *(Pre-authorization required after 6 visits)*	$75 Copay *(8 visits per Plan Year, combined with occupational and physical therapy)*	$75 Copay *(10 visits per Plan Year, combined with occupational and physical therapy)*	$75 Copay *(12 visits per Plan Year, combined with occupational and physical therapy)*

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Physical Therapy *(Pre-authorization required after 6 visits)*	$75 Copay *(8 visits per Plan Year, combined with occupational and speech therapy)*	$75 Copay *(10 visits per Plan Year, combined with occupational and speech therapy)*	$75 Copay *(12 visits per Plan Year, combined with occupational and speech therapy)*
Occupational Therapy *(Pre-authorization required after 6 visits)*	$75 Copay *(8 visits per Plan Year, combined with physical and speech therapy)*	$75 Copay *(10 visits per Plan Year, combined with physical and speech therapy)*	$75 Copay *(12 visits per Plan Year, combined with physical and speech therapy)*
Applied Behavioral Analysis	$75 Copay *(8 visits per Plan Year)*	$75 Copay *(10 visits per Plan Year)*	$75 Copay *(12 visits per Plan Year)*
Home Health Care *(Pre-authorization required)*	$50 Copay *(10 visits per Plan Year)*	$50 Copay *(15 visits per Plan Year)*	$50 Copay *(20 visits per Plan Year)*
Hospice Care	Not covered	Not covered	Not covered
Skilled Nursing Facility	Not covered	Not covered	Not covered
Cardiac Rehabilitation *(Pre-authorization required)*	Not Covered	Not Covered	$75 Copay *(12 visits per Plan Year)*
Durable Medical Equipment (DME)	Not covered	Not covered	Not covered
Diabetic Education and Supplies *(When utilizing Connect DME)* *(Continuous glucose monitors are covered under DME)*	Not covered	Not covered	$35 Copay
Prosthetics, Orthotics, Supplies and Surgical Dressings	Not covered	Not covered	Not covered
Dialysis	Not covered	Not covered	Not covered
Infusion Therapy	Not covered	Not covered	Not covered
Chemotherapy & Radiation	Not covered	Not covered	Not covered
Transplant	Not covered	Not covered	Not covered
Pharmacy Benefits Retail Option – 30 day Supply			
Preventive Generic Drugs *(Preferred Brand)*	$0 Copay/drug	$0 Copay/drug	$0 Copay/drug
Generic Drugs *(Preferred Brand)*	$5 Copay/drug	$5 Copay/drug	$5 Copay/drug
Preferred Brand Drugs	Not covered	$75 Copay/drug	$75 Copay/drug
Non-Preferred Brand Drugs	Not covered	$150 Copay/drug	$150 Copay/drug
Specialty Drugs	Not covered	Not covered	Not covered
Retail Option – 90-day Supply			
Generic Drugs *(Preferred Brand)*	$15 Copay/drug	$15 Copay/drug	$15 Copay/drug
Preferred Brand Drugs	Not covered	$225 Copay/drug	$225 Copay/drug
Non-Preferred Brand Drugs	Not covered	$450 Copay/drug	$450 Copay/drug
Specialty Drugs	Not covered	Not covered	Not covered

DISCLAIMER: BENEFITS LISTED ON THIS PROPOSAL ARE INTENDED TO BE A BRIEF SUMMARY AND ARE SUBJECT TO CHANGE, REFER TO THE SUMMARY OF BENEFITS FOR FULL DETAILS OF THE BENEFITS INCLUDING DESCRIPTION OF COVERAGE AND A LIST OF EXCLUSIONS.