Platinum Plan Options

PLAN	IHP PLATINUM $0 RBP	IHP PLATINUM $1500 RBP	IHP PLATINUM $2500 RBP	IHP PLATINUM $5000 RBP	IHP PLATINUM $7500 RBP
Network	PHCS	PHCS	PHCS	PHCS	PHCS
Deductible *(Individual/Family)*	$0/$0	$1,500/$3,000	$2,500/$5,000	$5,000/$10,000	$7,500/$15,000
Maximum Out of Pocket *(Individual/Family)*	$9,100/$18,200	$9,100/$18,200	$9,100/$18,200	$7,500/$15,000	$7,500/$15,000
Preventive Care					
Routine Well Care *(Non-Hospital Services)*	Included	Included *(Deductible waived)*	Included *(Deductible waived)*	Included *(Deductible waived)*	Included *(Deductible waived)*
Routine Well Care *(Hospital Services)*	Not covered	Not covered	Not covered	Not covered	Not covered
Physician Services					
Primary Care Office Visit *(Includes mental and behavioral health)*	$25 Copay	$25 Copay *(Deductible waived)*	$25 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Specialist Office Visit	$50 Copay	$50 Copay *(Deductible waived)*	$50 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
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 *(Deductible waived)*	$50 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Other Services Performed in Physician Office	$50 Copay	$50 Copay *(Deductible waived)*	$50 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Telemedicine	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited, Deductible waived)*	$0 Copay *(Unlimited, Deductible waived)*	0% Coinsurance *(Deductible waived)*	0% Coinsurance *(After deductible is met)*
Urgent Care	$75 Copay	$75 Copay *(Deductible waived)*	$75 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Diagnostic Testing (Subject to RBP – Except for Laboratory Services)					
Radiology & Advanced Imaging *(When utilizing Medmo)*	$0 Copay	$0 Copay *(Deductible waived)*	$0 Copay *(Deductible waived)*	0% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Radiology *(Non-Hospital Services) (Outside Medmo)*	$50 Copay	$50 Copay *(Deductible waived)*	$50 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Advanced Imaging *(Non-Hospital Services) (Outside Medmo)*	$50 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Laboratory *(Non-Hospital Services)*	$50 Copay	$50 Copay *(Deductible waived)*	$50 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Laboratory, Radiology & Advanced Imaging *(Hospital Services)*	Not covered	Not covered	Not covered	Not covered	Not covered
Hospital, Emergency & Facility Services (Subject to RBP)					
Ambulance *(Ground Only)*	$500 Copay	$500 Copay *(Deductible waived)*	$500 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Emergency	$750 Copay	$750 Copay *(Deductible waived)*	$750 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Non-Emergency	Not covered	Not covered	Not covered	Not covered	Not covered
Inpatient Facility *(Pre-authorization required)*	$750 Copay/per admission	$750 Copay/per admission *(After deductible is met)*	$750 Copay/per admission *(After deductible is met)*	30% Coinsurance/per admission *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
NICU	$750 Copay	$750 Copay *(After deductible is met)*	$750 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Outpatient Services or Surgery *(Pre-authorization required)*	$350 Copay	$350 Copay *(After deductible is met)*	$350 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Ambulatory Surgical or Outpatient Surgical Facility *(Pre-authorization required)*	$350 Copay	$350 Copay *(After deductible is met)*	$350 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Second Surgical Opinion *(Must utilize VezaHealth)*	$0 Copay *(Unlimited)*	$0 Copay *(Unlimited, Deductible waived)*	$0 Copay *(Unlimited, Deductible waived)*	0% Coinsurance *(Unlimited, Deductible waived)*	0% Coinsurance *(Unlimited, Deductible waived)*
Maternity Services (Subject to RBP)					
Inpatient Facility *(Copay is in addition to the inpatient Copay)*	$750 Copay/per admission	$750 Copay/per admission *(After deductible is met)*	$750 Copay/per admission *(After deductible is met)*	30% Coinsurance/per admission *(After deductible is met)*	0% Coinsurance/per admission *(After deductible is met)*
Professional Services	$350 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Mental or Nervous Disorders or Substance Abuse Treatment (Subject to RBP)					
Inpatient Facility *(Preauthorization required)*	$750 Copay/per admission	$750 Copay/per admission *(After deductible is met)*	$750 Copay/per admission *(After deductible is met)*	30% Coinsurance/per admission *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Outpatient Facility *(Preauthorization required)*	$350 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*

Other Services PLAN	IHP PLATINUM $0 RBP	IHP PLATINUM $1500 RBP	IHP PLATINUM $2500 RBP	IHP PLATINUM $5000 RBP	IHP PLATINUM $7500 RBP
Hospice Care (Subject to RBP)					
Hospital Services	$750 Copay	$750 Copay *(After deductible is met)*	$750 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Freestanding Facility or Clinic	$350 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Home Based Services	$100 Copay	$100 Copay *(Deductible waived)*	$100 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Dialysis (Subject to RBP)					
Hospital Services	$750 Copay	$750 Copay *(After deductible is met)*	$750 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Freestanding Facility or Clinic	$350 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Home Based Services	$100 Copay	$100 Copay *(Deductible waived)*	$100 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Infusion Therapy					
Hospital Services	$750 Copay	$750 Copay *(After deductible is met)*	$750 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Freestanding Facility or Clinic	$350 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Home Based Services	$100 Copay	$100 Copay *(Deductible waived)*	$100 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Chemotherapy Infusion (Not Oral) & Radiation					
Hospital Services	$750 Copay	$750 Copay *(After deductible is met)*	$750 Copay *(After deductible is met)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Freestanding Facility or Clinic	$350 Copay	$350 Copay *(Deductible waived)*	$350 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Home Based Services	$100 Copay	$100 Copay *(Deductible waived)*	$100 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Other Services					
Chiropractic Care	$75 Copay *(10 visits per Plan Year)*	$75 Copay *(10 visits per Plan Year, Deductible waived)*	$75 Copay *(10 visits per Plan Year, Deductible waived)*	30% Coinsurance *(10 visits per Plan Year. After deductible is met)*	0% Coinsurance *(10 visits per Plan Year. After deductible is met)*
Speech Therapy *(Pre-authorization required after 6 visits)*	$75 Copay *(20 visits per Plan Year, combined with occupational and physical therapy)*	$75 Copay *(20 visits per Plan Year combined with occupational and physical therapy. Deductible waived)*	$75 Copay *(20 visits per Plan Year combined with occupational and physical therapy. Deductible waived)*	30% Coinsurance *(20 visits per Plan Year combined with occupational and physical therapy. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year combined with occupational and physical therapy. After deductible is met)*
Physical Therapy *(Pre-authorization required after 6 visits)*	$75 Copay *(20 visits per Plan Year, combined with occupational and speech therapy)*	$75 Copay *(20 visits per Plan Year combined with occupational and speech therapy. Deductible waived)*	$75 Copay *(20 visits per Plan Year combined with occupational and speech therapy. Deductible waived)*	30% Coinsurance *(20 visits per Plan Year combined with occupational and speech therapy. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year combined with occupational and speech therapy. After deductible is met)*
Occupational Therapy *(Pre-authorization required after 6 visits)*	$75 Copay *(20 visits per Plan Year, combined with physical and speech therapy)*	$75 Copay *(20 visits per Plan Year combined with physical and speech therapy. Deductible waived)*	$75 Copay *(20 visits per Plan Year combined with physical and speech therapy. Deductible waived)*	30% Coinsurance *(20 visits per Plan Year combined with physical and speech therapy. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year combined with physical and speech therapy. After deductible is met)*
Applied Behavioral Analysis	$75 Copay *(20 visits per Plan Year)*	$75 Copay *(20 visits per Plan Year. Deductible waived)*	$75 Copay *(20 visits per Plan Year. Deductible waived)*	30% Coinsurance *(20 visits per Plan Year. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year. After deductible is met)*
Home Health Care *(Pre-authorization required)*	$50 Copay *(20 visits per Plan Year)*	$50 Copay *(20 visits per Plan Year. Deductible waived)*	$50 Copay *(20 visits per Plan Year. Deductible waived)*	30% Coinsurance *(20 visits per Plan Year. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year. After deductible is met)*
Skilled Nursing Facility	$750 Copay *(30 days per Plan Year)*	$750 Copay *(30 days per Plan Year. After deductible is met)*	$750 Copay *(30 days per Plan Year. After deductible is met)*	30% Coinsurance *(30 days per Plan Year. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year. After deductible is met)*
Cardiac Rehabilitation *(Pre-authorization required)*	$75 Copay *(20 visits per Plan Year)*	$75 Copay *(20 visits per Plan Year. Deductible waived)*	$75 Copay *(20 visits per Plan Year. Deductible waived)*	30% Coinsurance *(20 visits per Plan Year. After deductible is met)*	0% Coinsurance *(20 visits per Plan Year. After deductible is met)*
Durable Medical Equipment (DME)	$250 Copay	$250 Copay *(Deductible waived)*	$250 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Diabetic Education and Supplies *(When utilizing Connect DME) (Continuous glucose monitors are covered under DME)*	$35 Copay	$35 Copay *(Deductible waived)*	$35 Copay *(Deductible waived)*	0% Coinsurance *(After Deductible is met)*	0% Coinsurance *(After Deductible is met)*
Prosthetics, Orthotics, Supplies and Surgical Dressings	$250 Copay	$250 Copay *(Deductible waived)*	$250 Copay *(Deductible waived)*	30% Coinsurance *(After deductible is met)*	0% Coinsurance *(After deductible is met)*
Transplant	Not covered	Not covered	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	$0 Copay/drug *(Deductible waived)*	$0 Copay/drug *(Deductible waived)*
Generic Drugs *(Preferred Brand)*	$5 Copay/drug	$5 Copay/drug	$5 Copay/drug	$5 Copay/drug *(After deductible is met)*	$5 Copay/drug *(After deductible is met)*
Preferred Brand Drugs	$75 Copay/drug	$75 Copay/drug	$75 Copay/drug	$75 Copay/drug *(After deductible is met)*	$75 Copay/drug *(After deductible is met)*
Non-Preferred Brand Drugs	$150 Copay/drug	$150 Copay/drug	$150 Copay/drug	$150 Copay/drug *(After deductible is met)*	$150 Copay/drug *(After deductible is met)*
Specialty Drugs	Not covered	Not covered	Not covered	Not covered	Not covered

PLAN Retail Option – 90-day Supply	IHP PLATINUM $0 RBP	IHP PLATINUM $1500 RBP	IHP PLATINUM $2500 RBP	IHP PLATINUM $5000 RBP	IHP PLATINUM $7500 RBP
Generic Drugs *(Preferred Brand)*	$15 Copay/drug	$15 Copay/drug	$15 Copay/drug	$15 Copay/drug *(After deductible is met)*	$15 Copay/drug *(After deductible is met)*
Preferred Brand Drugs	$225 Copay/drug	$225 Copay/drug	$225 Copay/drug	$225 Copay/drug *(After deductible is met)*	$225 Copay/drug *(After deductible is met)*
Non-Preferred Brand Drugs	$450 Copay/drug	$450 Copay/drug	$450 Copay/drug	$450 Copay/drug *(After deductible is met)*	$450 Copay/drug *(After deductible is met)*
Specialty Drugs	Not covered	Not covered	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.