

IHA Health Plan Comparison

BENEFIT SUMMARY	1500 CLASSIC	2500 CLASSIC	3500 CLASSIC
PPO NATIONAL NETWORK	First Health PPO	First Health PPO	First Health PPO
Individual Deductible	\$1,500 In / \$3,000 Out	\$2,500 In / \$5,000 Out	\$3,500 In / \$7,000 Out
Family Deductible	\$3,000 In / \$6,000 Out	\$5,000 In / \$10,000 Out	\$7,000 In / \$14,000 Out
Individual Max Out-of-Pocket	\$7,350 In / \$14,700 Out	\$7,350 In / \$14,700 Out	\$7,350 In / \$14,700 Out
Family Max Out-of-Pocket	\$14,700 In / \$29,400 Out	\$14,700 In / \$29,400 Out	\$14,700 In / \$29,400 Out
Preventive Care	100% Deductible Waived	100% Deductible Waived	100% Deductible Waived
Lifetime Max	No Maximum	No Maximum	No Maximum
Primary Care Visit Co-Pay	\$40	\$40	\$45
Specialist Care Visit Co-pay	\$80	\$80	\$90
Non-Network Providers & Facilities	Plan pays 60% after non-network deductible		
Laboratory & Diagnostic Services			
Facility	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Professional Fees	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Radiology Services			
Facility (CT/PET/MRI/MRA/SPECT)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Professional Fees	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Free Standing Facility (x-ray & lab only)	Plan Pays 100% (After Deductible)	Plan Pays 100% (After Deductible)	Plan Pays 100% (After Deductible)
Telemedicine coverage provided by MyIdealDr.com 855-879-4332 Group #MYIDR1695			
Facility & Professional Services			
Emergency Room - Professional Fee	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Emergency Room – Facility	80%* of plan allowable (After Deductible)	80%* of plan allowable (After Deductible)	80%* of plan allowable (After Deductible)
Inpatient Hospital - Physician Fees	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Inpatient – Facility	80% of plan allowable (After Deductible)	80% of plan allowable (After Deductible)	80% of plan allowable (After Deductible)
Outpatient – Physician	Plan pays 80% * (After Deductible)	Plan pays 80%* (After Deductible)	Plan pays 80%* (After Deductible)
Outpatient Hospital – Facility	80%* of plan allowable (After Deductible)	80%* of plan allowable (After Deductible)	80%* of plan allowable (After Deductible)
Urgent Care Co-Pay	\$80	\$80	\$90
For more information about limitations and exceptions, see the plan or policy document at www.myperformancehlth.com			
Prescription Drug Benefit – Magellan Rx at (800) 424-3312 **Non participating pharmacies are not covered**			
Generic	Retail: \$15 co-pay	Retail: \$15 co-pay	Retail: \$15 co-pay
Preferred Brand	Retail: \$45 co-pay	Retail: \$45 co-pay	Retail: \$65 co-pay
Non-Preferred Brand	Retail: \$85 co-pay	Retail: \$85 co-pay	Retail: \$100 co-pay
Specialty	Excluded/Not Covered		

This is for general comparison purposes only and is not a legal document. Please refer to the Summary of Benefit Coverage and Summary Plan Document for all legal descriptions. All Benefits are subject to plan allowable and out of pocket maximums. * Once the client pays their Calendar Year Out of Pocket Maximum, the plan will pay 100%.