Enroll Prime

BMI

PHCS Network

Administered by:

MBA EMPLOYEE BENEFITS

MEC Options

Plan	CLASSIC	CHOICE
NETWORK	PHCS	PHCS
Deductible (Indv/Fam)	$0 / $0	$0 / $0
Maximum Out of Pocket (Indv/Fam)	N / A	$8,700 / $17,400
Preventive, Physician & Diagnostic Services		
Preventive & Wellness (Non-Hospital Based)	Included	Included
Primary Care Office Visit (Non-Hospital Based)	NOT COVERED	$35 Copay
Specialist Office Visit (Non-Hospital Based) (Includes Mental and Behavioral Health)	NOT COVERED	$75 Copay
Urgent Care	NOT COVERED	$85 Copay
Telemedicine	$0 Copay (Unlimited)	$0 Copay (Unlimited)
Laboratory Services & Radiology (Non-Hospital Based)	NOT COVERED	$50 Copay
CT / MRI / MRA / PET Scan (Non-Hospital Based) (Prior Authorization Required)	NOT COVERED	$500 Copay (3x/yr)
Outpatient Hospital & Facility Services		
Outpatient Hospital or Free- Standing Facility Services and Surgery (Prior Authorization Required)	NOT COVERED	NOT COVERED
Anesthesia	NOT COVERED	NOT COVERED
Second Surgical Opinion	NOT COVERED	NOT COVERED
Pharmacy Benefits (Subject to Formulary)		
Preventive (Generic Only)	$0 Copay	$0 Copay
Non-Preventive (Retail)	NOT COVERED	$5 Copay (Generic)

Plan		
Employee	$127.50	$209.10
Employee & Spouse	$181.90	$290.70
Employee & Child(ren)	$181.90	$290.70
Family	$231.67	$399.50

These plans are not traditional major medical insurance. These are limited day benefit plans. These plans have exclusions and limitations not associated with major medical plans. Please review the Summary of Benefits for each plan for a description of coverage and a list of exclusions.

DVP Options

Plan	ESSENTIALS 7500	ESSENTIALS 5000	ESSENTIALS 2500
NETWORK	PHCS	PHCS	PHCS
Deductible (Indv/Fam)	$7,500 / $15,000	$5,000 / $10,000	$2,500 / $5,000
Maximum Out of Pocket (Indv/Fam)	$9,200 / $18,400	$9,200 / $18,400	$9,200 / $18,400
Preventive, Physician & Diagnostic Services			
Preventive & Wellness (Non- Hospital Based)	Included	Included	Included
Primary Care Office Visit (Non- Hospital Based)	$50 Copay (2 visits per plan year*)	$25 Copay (2 visits per plan year*)	$25 Copay (4 visits per plan year*)
Specialist Office Visit (Non-Hospital Based) (Includes Mental and Behavioral Health)	$75 Copay (2 visits per plan year*)	$50 Copay (2 visits per plan year*)	$50 Copay (4 visits per plan year*)
Urgent Care	$75 Copay (1 visit per plan year)	$75 Copay (1 visit per plan year)	$75 Copay (1 visit per plan year)
Telemedicine	$0 Copay (Unlimited)	$0 Copay (Unlimited)	$0 Copay (Unlimited)
Laboratory Services & Radiology (Non-Hospital Based)	Deductible + 50% (3 visits per plan year)	Deductible + 50% (3 visits per plan year)	Deductible + 50% (3 visits per plan year)
CT / MRI / MRA / PET Scan (Non-Hospital Based) (Prior Authorization Required)	Deductible + 50% (1 visit per plan year)	Deductible + 50% (1 visit per plan year)	Deductible + 50% (1 visit per plan year)
Allergy Services (Applied to PCP or Specialist Office visit limits)	$50 Copay	$25 Copay	$25 Copay

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*Primary Care & Specialist Visits are combined limits.

Hospital & Facility Services

Inpatient Hospitalization (per admission) (Prior Authorization Required)	**Deductible + 50% (5 days per plan year)**	**Deductible + 50% (5 days per plan year)**	**Deductible + 50% (5 days per plan year)**
Inpatient Visits - Physician	**Included in IP Hospitalization Copay**	**Included in IP Hospitalization Copay**	**Included in IP Hospitalization Copay**
Inpatient Surgery (Prior Authorization Required)	**Included in IP Hospitalization Copay (1 surgery per plan year**)**	**Included in IP Hospitalization Copay (1 surgery per plan year**)**	**Included in IP Hospitalization Copay (1 surgery per plan year**)**
Outpatient Hospital or Free- Standing Facility Services and Surgery (Prior Authorization Required)	**Deductible + 50% (1 visit per plan year**)**	**Deductible + 50% (1 visit per plan year**)**	**Deductible + 50% (1 visit per plan year**)**
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 Copay**
Emergency Room	**Deductible + 50% (1 visit per plan year)**	**Deductible + 50% (1 visit per plan year)**	**Deductible + 50% (1 visit per plan year)**
Ambulance Service (Ground Services Only)	**Deductible + 50% (1 per plan year)**	**Deductible + 50% (1 per plan year)**	**Deductible + 50% (1 per plan year)**
Second Surgical Opinion	**Deductible + 50%**	**Deductible + 50%**	**Deductible + 50%**

Pregnancy Benefits

Professional Services	**Not Covered**	**Not Covered**	**Not Covered**
Maternity / Childbirth / Delivery (per admission) (Considered Inpatient Hospital Stay) (Prior Authorization Required)	**Not Covered**	**Not Covered**	**Not Covered**

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**Inpatient & Outpatient Surgery limits are combined for 1 per year.

Other Services			
Home Health Care (Prior Authorization Required)	Deductible + 50% (10 visits per plan year)	Deductible + 50% (10 visits per plan year)	Deductible + 50% (10 visits per plan year)
Treatment for Chemical Abuse & Dependency – Inpatient (per Day) (Prior Authorization Required)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)
Treatment for Chemical Abuse & Dependency – Outpatient (per day) (Prior Authorization Required)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)
Rehabilitation / Habilitation Services (Physical, Speech, and Occupational) (Prior Authorization Required)	Not Covered	Not Covered	Not Covered

Pharmacy Benefits (Subject to Formulary) Mail Order copay is 3x's the retail copay for a 3-month supply where applicable.			
Preventive (Generic Only)	$0 Copay	$0 Copay	$0 Copay
Generic Non-Preventive (Retail)	Discount Plan	Discount Plan	Discount Plan
Preferred Brand Non-Preventive (Retail)	Not Covered	Not Covered	Not Covered
Non-Preferred Brand-Preventive (Retail)	Not Covered	Not Covered	Not Covered

Plan	ESSENTIALS 7500	ESSENTIALS 5000	ESSENTIALS 2500
Employee	$372.28	$433.48	$514.08
Employee & Spouse	$616.08	$677.28	$718.08
Employee & Child(ren)	$565.08	$626.28	$667.08
Family	$830.28	$891.48	$973.08

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MVP Options

Plan	BASIC	VALUE	ADVANTAGE
NETWORK	PHCS	PHCS	PHCS
Deductible (Indv/Fam)	$0 / $0	$0 / $0	$0 / $0
Maximum Out of Pocket (Indv/Fam)	$8,700 / $17,400	$5,000 / $10,000	$5,000 / $10,000
Preventive, Physician & Diagnostic Services			
Preventive & Wellness (Non- Hospital Based)	Included	Included	Included
Primary Care Office Visit (Non- Hospital Based)	$25 Copay (8 visits per plan year)	$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)	$50 Copay (8 visits per plan year)	$25 Copay (10 visits per plan year)	$25 Copay (12 visits per plan year)
Urgent Care	$50 Copay (2 visits per plan year)	$35 Copay (3 visits per plan year)	$35 Copay (3 visits per plan year)
Telemedicine	$0 Copay (Unlimited)	$0 Copay (Unlimited)	$0 Copay (Unlimited)
Laboratory Services & Radiology (Non-Hospital Based)	$50 Copay (3 visits per plan year)	$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 per plan year)	$350 Copay (2 per plan year)	$350 Copay (3 per plan year)
Allergy Services (Applied to PCP or Specialist Office visit limits)	$25 Copay	$25 Copay	$25 Copay

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Hospital & Facility Services

Inpatient Hospitalization (per admission) (Prior Authorization Required)	**$350 Copay** (5 days per plan year)	**$350 Copay** (7 days per plan year)	**$350 Copay** (10 days per plan year)
Inpatient Visits - Physician	**Included in IP Hospitalization Copay**	**Included in IP Hospitalization Copay**	**Included in IP Hospitalization Copay**
Inpatient Surgery (Prior Authorization Required)	**Included in IP Hospitalization Copay** (2 surgeries per plan year)	**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 visit per plan year)	**$350 Copay** (2 visits per plan year)	**$350 Copay** (2 visits per plan year)
Anesthesia	**Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay** (2 IP and 1 OP per plan year)	**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 visit per plan year)	**$350 Copay** (1 visit per plan year)	**$350 Copay** (2 visits per plan year)
Ambulance Service (Ground Services Only)	**$250 Copay** (1 per plan year)	**$250 Copay** (1 per plan year)	**$250 Copay** (2 per plan year)
Second Surgical Opinion	**$0 Copay**	**$0 Copay**	**$0 Copay**

Pregnancy Benefits

12 - Month Waiting Period

Professional Services	**Not Covered**	**$350 Copay**	**$350 Copay**
Maternity / Childbirth / Delivery (per admission) (Considered Inpatient Hospital Stay) (Prior Authorization Required)	**Not Covered**	**$350 Copay**	**$350 Copay**

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Other Services			
Home Health Care (Prior Authorization Required)	**$25 Copay (10 visits per plan year)**	**$25 Copay (15 visits per plan year)**	**$25 Copay (20 visits per plan year)**
Treatment for Chemical Abuse & Dependency – Inpatient (per Day) (Prior Authorization Required)	**$250 Copay (5 days per plan year)**	**$250 Copay (7 days per plan year)**	**$250 Copay (10 days per plan year)**
Treatment for Chemical Abuse & Dependency – Outpatient (per day) (Prior Authorization Required)	**$25 Copay (5 days per plan year)**	**$25 Copay (7 days per plan year)**	**$25 Copay (10 days per plan year)**
Rehabilitation / Habilitation Services (Physical, Speech, and Occupational) (Prior Authorization Required)	**Not Covered**	**Not Covered**	**$50 Copay per Day (12 visits per plan year)**

Pharmacy Benefits (Subject to Formulary)* Mail Order copay is 3x's the retail copay for a 3-month supply where applicable.			
Preventive (Generic Only)	**$0 Copay**	**$0 Copay**	**$0 Copay**
Generic Non-Preventive (Retail)	**$5 Copay (Generic)**	**$5 Copay**	**$5 Copay**
Preferred Brand Non-Preventive (Retail)	**Not Covered**	**Not Covered**	**Not Covered**
Non-Preferred Brand-Preventive (Retail)	**Not Covered**	**Not Covered**	**Not Covered**

Plan	BASIC	VALUE	ADVANTAGE
Employee	$583.51	$644.12	$691.45
Employee & Spouse	$925.24	$1,058.60	$1,138.10
Employee & Child(ren)	$818.80	$927.93	$989.21
Family	$1,160.54	$1,342.39	$1,435.86

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FAQ: Frequently Asked Questions

1. What Providers are In-Network?
Providers that participate with the national PHCS PPO network!

2. Where can I use my plan?
In all 50 states!

3. Do I need a referral to see a specialist?
No, go to any in-network specialist to access an affordable co-pay.

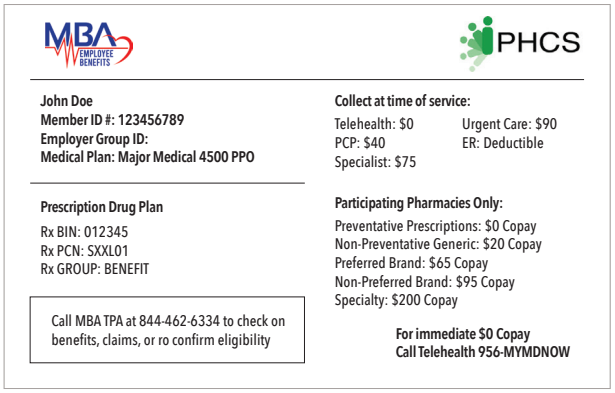
4. What Pharmacies are in network?
All national recognized pharmacies (Walmart, CVS, Walgreens, and many local pharmacies as well)!

5. When should I use an Emergency Room vs Urgent Care?
Most medical conditions can be treated at an Urgent Care facility. By choosing Urgent Care, your cost may be greatly reduced compared to an ER visit. However, if you are experiencing an extreme medical condition such as stroke, heart attack, uncontrolled bleeding, severe burns, or electrical shock, please go directly to the nearest Emergency Room. The average cost for an Urgent Care visit is $90 to $100, while the average cost for an Emergency Room visit is $1,300 to $3,000.

6. Do I Need prior authorization for services?
Yes, most services outside of Primary Care or Specialist will require prior authorization.

6. What will my ID card look like?

Front of Card



Back of Card