PHBP
Producers' Health Benefits Plan

2019 Staff Medical Plan Options

PHBP Staff Plan Options:	PHBP Classic Premier PPO		PHBP Classic Plus PPO		PHBP California Classic HMO (CA Only)		PHBP Health Savings Account (HSA)	
Anthem Plan Designations	Anthem Classic PPO 500/25/20		Anthem Classic PPO 500/30/20		Anthem Classic HMO 10/30/250 Admit/125 OP		Anthem PPO HAS 2700/20	
DEDUCTIBLE	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Individual	$500	$1,500	$500	$1,500	$0	Not Applicable	$2,700	$8,100
Family	$1,000	$3,000	$1,000	$3,000	$0	Not Applicable	$5,400	$16,200
OUT-OF-POCKET MAX								
Individual OOP	$2,500	$5,000	$4,000	$12,000	$2,000	Not Applicable	$5,000	$15,000
Family OOP	$5,000	$10,000	$8,000	$24,000	$4,000	Not Applicable	$10,000	$30,000
PHYSICIAN SERVICES								
Office Visit Copays	$25	50% coinsurance	$30 copay	50% coinsurance	$10	Not Covered	20% coinsurance	50% coinsurance
Preventive Care	$0	50% coinsurance	$0	50% coinsurance	$0	Not Covered	$0	50% coinsurance
Diagnostic Lab/X-Ray	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$0	Not Covered	20% coinsurance	50% coinsurance
Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$100 copay per test	Not Covered	20% coinsurance	50% coinsurance
Rehabilitation/Habilitation (PT/OT/ST)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Chiropractic Care	$20 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Acupuncture	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
PRESCRIPTION DRUGS								
Tier 1 (Generic Formulary)	$10	$10 + 50% coinsurance	$5/$20	50% up to $250	$5/$20	50% up to $250	$5/$15	50% up to $250
Tier 2 (Preferred Brand Formulary)	$30	$30 + 50% coinsurance	$40	50% up to $250	$40	50% up to $250	$40	50% up to $250
Tier 3 (Non-Preferred Brand Formulary)	$50	$50 + 50% coinsurance	$65	50% up to $250	$65	50% up to $250	$60	50% up to $250
Tier 4 (Specialty Drugs)	$500 Deductible 30% up to $150	50% coinsurance	30% up to $250	50% up to $250	30% up to $250	50% up to $250	30% up to $250	50% up to $250
Mail Order	T1: $10 T2: $60 T3: $100 T4: 30% up to $300	50% coinsurance	T1:$12.50 T2:$120 T3:$165 T4:30% up to $250	50% up to $250	T1:$12.50 T2:$120 T3:$165 T4:30% up to $250	50% up to $250	T1:$12.50 T2:$120 T3:$180 T4:30% up to $250	50% up to $250
HOSPITAL FACILITY SERVICES								
Inpatient Hospital Services	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
Outpatient Surgery in a Hospital	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$125 copay per admit	Not Covered	20% coinsurance	50% coinsurance
Ambulatory Surgical Center	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$125 copay per admit	Not Covered	20% coinsurance	50% coinsurance
EMERGENCY SERVICES								
Emergency Room	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance	$100 copay per visit	Covered as In Network	20% coinsurance	20% coinsurance
Emergency	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	$100 copay per trip	Covered as In Network	20% coinsurance	20% coinsurance
Urgent Care	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Covered as In Network	20% coinsurance	50% coinsurance
MENTAL HEALTH/SUBSTANCE USE DISORDER								
Outpatient Services	$20 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Inpatient Services	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
MATERNITY								
Prenatal and Postnatal Care	$25 copay per visit	50% coinsurance	$30 copay per visit	50% coinsurance	$10 copay per visit	Not Covered	20% coinsurance	50% coinsurance
Delivery & All Inpatient Services	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
MEDICAL RATES								
EE	**$612.13**		**$576.35**		**$441.26**		**$408.19**	
EE + SP	**$1,359.63**		**$1,280.20**		**$980.12**		**$906.67**	
EE + CH	**$1,112.42**		**$1,047.44**		**$801.92**		**$741.83**	
FAM	**$1,912.93**		**$1,801.18**		**$1,378.98**		**$1,275.65**	