PHBP California Medical Plans Comparison

	PHBP CA Classic HMO		PHBP Classic Premier PPO	
DEDUCTIBLE	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Individual	$0	Not Applicable	$500	$1,500
Family	$0	Not Applicable	$1,000	$3,000
OUT-OF-POCKET MAX	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Individual OOP	$2,000	Not Applicable	$2,500	$5,000
Family OOP	$4,000	Not Applicable	$5,000	$10,000
PHYSICIAN SERVICES	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Office Visit Copays	$10	Not Covered	$25	50% coinsurance
Preventive Care	$0	Not Covered	$0	50% coinsurance
Diagnostic Lab/X-Ray	$0	Not Covered	20% coinsurance	50% coinsurance
Imaging (CT/PET scans MRIs)	$100 copay per test	Not Covered	20% coinsurance	50% coinsurance
Rehabilitation/ Habilitation	$10 copay per test	Not Covered	20% coinsurance	50% coinsurance
Chriopractic Care	$10 copay per test	Not Covered	$20 copay per visit	50% coinsurance
Acuouncture	$10 copay per test	Not Covered	$25 copay per visit	50% coinsurance
PRESCRIPTION DRUGS	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Tier 1 (Generic Formulary)	$5/$20	50% up to $250	$10	$10+50% coinsurance
Tier 2 (Preferred Brand)	$40	50% up to $250	$30	$30+50% coinsurance
Tier 3 (Non-Preferred Brand)	$65	50% up to $250	$50	$50+50% coinsurance
Tier 4 (Specialty Drugs)	30% up to $250	50% up to $250	$500 deductible, 30% up to $12(	50% coinsurance
Mail Order	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% coinsurance
HOSPITAL FACILITY SERVICES	**in -Network**	**Non-Network**	**In-Network**	**Non-Network**
Inpatient Hospital Services	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
Outpatient Surgery in a Hospital	$125 copay per admit	Not Covered	20% coinsurance	50% coinsurance
Ambulatory Surgical Center	$125 copay per admit	Not Covered	20% coinsurance	50% coinsurance
EMERGENCY SERVICES	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Emergency Room	$100 copay per visit	Covered as in Network	$150 copay per admit then 20% coinsurance	$150 copay per admit then 20% coinsurance
Emergency	$100 copay per visit	Covered as in Network	20% coinsurance	20% coinsurance
Urgent Care	$10 copay per visit	Covered as in Network	$25 copay per visit	50% coinsurance
MENTAL HEALTH/SUBSTANCE USE DISORDER	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Outpatient Services	$10 copay per visit	Not Covered	$20 copay per visit	50% coinsurance
Inpatient Services	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance
MATERNITY	**In -Network**	**Non-Network**	**In-Network**	**Non-Network**
Prenatal and Posnatal Care	$10 copay per visit	Not Covered	$25 copay per visit	50% coinsurance
Delivery & All Inpatient Services	$250 copay per admit	Not Covered	20% coinsurance	50% coinsurance