

2024 60-30 PLUS PLAN SUMMARY AT-A-GLANCE - WHAT THE MEMBER PAYS

In-Network Based on ALLOWABLE charges	60/30
Premium Information	
Monthly premium	\$ 315
Annual deductible	\$ 0
Out-of-pocket annual maximum	\$ 0
Lifetime maximum	\$ 500,000
Provider Care	
Primary care physician (non-specialist)	\$ 30
Preventative care / Wellness Exam	\$ 0
Specialty physician	\$ 45
Emergency & Urgent Care	
Emergency transport	\$ 0
Emergency room	\$ 175
Telemedicine (Doc on Demand) + Mental Health	\$ 10
Urgent care	\$ 30
Pharmacy (Maintenance from Depot Drug required)	
Annual cap	\$ 0
Preferred generic drugs (Tier 1) / Depot Drug	\$ 3
Generic drugs (Tier 2) / Depot Drug	\$ 10
Preferred brand drugs (Tier 3) / Depot Drug	\$ 20
Non-preferred brand drugs (Tier 4) / Depot Drug	\$ 75
Specialty drugs* (Tier 5) / Optum	Variable
Retail Network Pharmacy (Non-maintenance)	\$15, \$20, \$40, \$100
Diagnostic	
Blood work, etc.	\$ 0
Radiology	\$ 0
Imaging (scans, MRI, etc.) Pre-Certification required through Telligen 877-654-1375*	\$ 150
Outpatient procedures	
Facility fee (i.e.. Surgery center)	\$ 150
Physician fees	\$ 0
Inpatient / Hospitalization	
Facility fee (hospital)*	\$ 250
Physician fees	\$ 0
Mental health services	
Physician (non-specialist)	\$ 30
Physician (specialist)	\$ 45
Intensive outpatient services (per incident) *	\$ 250
Inpatient (per incident) *	\$ 250
Recovery, special care, rehabilitation	
Home health care*	\$ 0
Rehabilitation services*	\$ 0
Habilitation services	\$ 0
Skilled nursing*	\$ 0
Durable medical equipment (limited)	\$ 0
Hospice care*	\$ 0
Speech therapy	\$ 0

Chiropractic** (Plan pays up to \$600; see below)	20% of \$600
Physical therapy** (Plan pays up to \$1500; see below)	\$ 0
Other benefits	
Dialysis*	\$ 0
Diabetes	\$ 0

Plan Year 2024

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Transplants*	\$ 0
Hearing Services (includes aids, tests, etc.) annual maximum limit for 12 months is \$2000	\$ 0
Vision (Annual exams)	\$ 45
Complete Sleep Program (IRHC Pre Cert Required)	
CPAP Machine	\$ 75
CPAP Supplies	\$ 35
At home sleep study* Pre-Certification required 833-878-2727	\$ 0
In-lab sleep study*	\$ 150
Home oxygen Oxygen Concentrator for Long Term Therapy Greater Than 6 Months (\$150 Copay)	\$ 0
Sterilization	
Male	Not covered
Female	Not covered
Podiatry	
Office visit	\$ 45
Diabetic care	\$ 45
*Pre-certification is required	
**Chiropractic services member pays 20% of plan allowable. After plan maximum member is responsible for 100% of additional charges. *Physical Therapy limit of \$1,500 per year if additional therapy is needed and approved member pays 50% of plan allowable.	
Services outside of the United States is not a covered benefit	

2024