

What Is The Difference?

MaxGuard Plans vs 1M/5M Plans

MaxGuard Plans		VS	1M/5M Plans	
Type	Limited Medical (EPO)		Type	Limited Medical (RBP)
Name(s)	MaxGuard 300, 600, 900, 1500, 2000, 2500		Name(s)	PSM 1M/5M 250, 500, 750
Network	First Health Network		Network	PHCS Practitioner and Ancillary Only
Deductible Structure				
Plan	Individual	Family	Plan	Individual
300	\$300	\$600	250	\$250
600	\$600	\$1,200	500	\$500
900	\$900	\$1,800	750	\$750
1,500	\$1,500	\$3,000		\$500
2,000	\$2,000	\$4,000		\$1,000
2,500	\$2,500	\$5,000		\$1,500
Emergency Room Care				
Plan	Copay (after deductible)	Visit Limits	Plan	Copay (after deductible)
All	\$300	3 visits /benefit year	All	\$250
				2 accident + 2 sickness visits /benefit year
Emergency Medical Transportation				
Plan	Copay (after deductible)	Limits	Plan	Copay (after deductible)
All	\$500 Copay	1 Ground or Air Ambulance / Benefit Year	All	\$0 Copay (No Deductible)
				2 combined Ground/Air Ambulance / Benefit Year
Inpatient Hospital Services				
Plan	Copay (after deductible)	Limits	Plan	Copay (after deductible)
All	\$850 Copay /admission	3 hospitalizations (5 days each)	All	\$1,000 Copay /admission
				2 non-ICU + 3 ICU (10 days each)

MaxGuard Plans			VS	1M/5M Plans		
Inpatient Surgery						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$850 Copay with 3 surgeries/Benefit Year (Elective surgeries are not covered)			All	\$1,000	2 surgeries /Benefit Year
Outpatient Surgery						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$250 Copay with 3 surgeries/Benefit Year (Elective surgeries are not covered)			All	\$250	3 surgeries /Benefit Year
Mental Health, Behavioral Health and/or Substance Use Disorder Services						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$850 Copay /admission	3 hospitalizations (10 days each). Combined with annual Inpatient hospital limits.		All	\$250 Copay /admission	2 non-ICU + 3 ICU (10 days each) Combined with annual Inpatient hospital limits. Substance Abuse Services are not covered.
Allergy Shots						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$25	12 visits / Benefit Year		All	\$25	25 visits / Benefit Year
Cancer Treatment (Chemotherapy / Radiation & Infusion / Injection Drugs)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$100/visit	10 visits / Benefit Year combined.		All	\$100/visit	\$50,000 max / Benefit Year combined.
Diabetic Supplies						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	Diathrive Only	-		All	Diathrive: \$0 (\$250 for non-Diathrive.)	-

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Durable Medical Equipment						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$100/Item	\$500 max / Benefit Year		All	\$50/Item	\$500 max / Benefit Year
Maternity (Vaginal Delivery)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$0	2 day limit. Combined with Inpatient hospitalization limits.		All	\$250/Admission	\$15,000 max / Benefit Year. Combined with all maternity services.
Maternity (C-Section Delivery)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$0	4 day limit. Combined with Inpatient hospitalization limits.		All	\$500/Admission	\$15,000 max / Benefit Year. Combined with all maternity services.
Maternity (NICU)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$850 Copay /admission	5 days		All	Not Covered	-
Prosthetics & Orthotics						
Plan	Copay	Max Limit		Plan	Copay	Max Limit
All	\$250/Item	\$2,500 max / Benefit Year		All	\$50/Item	\$2,500 max / Benefit Year
Imaging (CT / PET Scans, MRI, MRA)						
Plan	Copay	Limits		Plan	Copay	Limits
All	\$500	3/Benefit Year		All	\$250	3/Benefit Year

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Therapy (Mental Health)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$50/Visit	10 visits per member / Benefit Year. Combined with Virtual Physician office visits, PCP office visits, Specialist office visits, and Urgent Care visits.		All	\$0 Tele-Health Platform Only.	4 visits / Benefit Year.
Therapy (Chiropractic, PT/OT/ST, Cardiac)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$50/Visit	16 visits per member / Benefit Year. Combined with Chiropractic, PT/OT/ST, Cardiac (Pre-Cert Required)		All	\$50/Visit	10 visits per member / Benefit Year. Combined with PCP, Specialist, Urgent Care visits, Chiropractic, PT/OT/ST, Cardiac (Pre-Cert Required).
Therapy (Pulmonary Rehab)						
Plan	Copay (after deductible)	Limits		Plan	Copay (after deductible)	Limits
All	\$50/Visit	16 visits per member / Benefit Year. Combined with Chiropractic, PT/OT/ST, Cardiac (Pre-Cert Required)		All	Not Covered	-
Prescription Drugs						
Home Delivery			Home Delivery			
ScriptCo. Can order 30-day or 90-day supply. Detego Health contributes \$6 toward each prescription, and member will be responsible for any remaining cost. For questions or assistance, call ScriptCo at 888-201-0334.			Costco Pharmacy. Can order 90-day supply. No Costco membership required. For questions or assistance, call Costco Customer Service at 800-607-6861.			
PBM and Formulary			PBM and Formulary			
Pharmacy Benefit Manager: Ventegra			Pharmacy Benefit Manager: Ventegra			
Prescription drug list: Ventegra Mini-Mec Formulary			Prescription drug list: Ventegra Acute Formulary			