$1250 BROAD PLAN

ZERO CARD ELIGIBLE

Calendar Year Deductible	$1,250 Ind. / $3,750 Family
Calendar Year Out-Of-Pocket Maximum	$3,500 Ind. / $10,500 Family
Coinsurance	20% after deductible
Primary Care	$25 copay
Specialist Visit	$50 copay
Teladoc Visit/Teladoc Dermatology Visit	$10 copay/$50 copay
Teladoc LPC Visit /Teladoc Psychiatrist Visit	$25 copay/$50 copay
Preventative Services	100%
Emergency Room	$250 copay, then 20% after deductible Copay waived if admitted
Mental Health Inpatient	20% after deductible
Mental Health Outpatient	$25 copay/$50 copay
Physical Therapy	20% after deductible
Occupational, Speech Therapy	$25 copay

PHARMACY PLAN

RX Deductible	$150 Per Ind. / $450 Per Family
Preferred Generic Drugs	$0
Non-Preferred Generic Drugs	$40
Preferred Brand Drugs	$75
Non-Preferred Brand Drugs	$125
Specialty Drugs	$200

**COVERAGE SHOWN FOR IN-NETWORK TREATMENT*

$1250 HIGH PERFORMANCE

ZERO CARD ELIGIBLE; NETWORK INCLUDES INTEGRIS AND OU CHILDREN'S HOSPITAL

Calendar Year Deductible	$1,250 Ind. / $3,750 Family
Calendar Year Out-Of-Pocket Maximum	$3,500 Ind. / $10,500 Family
Coinsurance	20% after deductible
Primary Care	$25 copay
Specialist Visit	$50 copay
Teladoc Visit/Teladoc Dermatology Visit	$10 copay/$50 copay
Teladoc LPC Visit /Teladoc Psychiatrist Visit	$25 copay/$50 copay
Preventative Services	100%
Emergency Room	$250 copay, then 20% after deductible Copay waived if admitted
Mental Health Inpatient	20% after deductible
Mental Health Outpatient	$25 copay/$50 copay
Physical Therapy	20% after deductible
Occupational, Speech Therapy	$25 copay

PHARMACY PLAN

RX Deductible	$150 Per Ind. / $450 Per Family
Preferred Generic Drugs	$0
Non-Preferred Generic Drugs	$40
Preferred Brand Drugs	$75
Non-Preferred Brand Drugs	$125
Specialty Drugs	$200

**COVERAGE SHOWN FOR IN-NETWORK TREATMENT*

FIRST DOLLAR COVERAGE HIGH PERFORMANCE NETWORK

$500 OF CLAIMS' INCURRED WILL BE COVERED UNDER FIRST DOLLAR COVERAGE, INCLUDES THE ZERO CARD

Calendar Year Deductible	$500 Ind. / $1,000 Family
$500 First Dollar Coverage	
Calendar Year Out-Of-Pocket Maximum	$5,500 Ind. / $11,000 Family
Coinsurance	50% after deductible
Primary Care	50% after deductible
Specialist Visit	50% after deductible
Teladoc Visit/ Teladoc Dermatology Visit	$10 copay/ 50% after deductible
Teladoc LPC Visit /Teladoc Psychiatrist Visit	50% after deductible
Preventative Services	100%
Emergency Room	$250 copay, then 50% after deductible Copay waived if admitted
Mental Health Inpatient	50% after deductible
Mental Health Outpatient	50% after deductible
Physical, Speech and Occupational Therapy	50% after deductible

PHARMACY PLAN

$0 RX Deductible	
Preferred Generic Drugs	$0
Non-Preferred Generic Drugs	$25
Preferred Brand Drugs	$50
Non-Preferred Brand Drugs	$125
Specialty Drugs	$150

*COVERAGE SHOWN FOR IN-NETWORK TREATMENT

HDHP WITHOUT HSA BROAD

HIGH DEDUCTIBLE HEALTH PLAN WITH NO HSA CONTRIBUTION
INCLUDES THE ZERO CARD

Calendar Year Deductible	$5,000 Ind. / $10,000 Family
Calendar Year Out-Of-Pocket Maximum	$7,900 Ind. / $15,800 Family
Coinsurance	20% after deductible
Primary Care	$35 copay
Specialist Visit	$60 copay
Teladoc Visit/Teladoc Dermatology Visit	$10 copay/ $60 copay
Teladoc LPC Visit /Teladoc Psychiatrist Visit	$35 copay/ $60 copay
Preventative Services	100%
Emergency Room	$250 copay, then 20% after deductible Copay waived if admitted
Mental Health Inpatient	20% after deductible
Mental Health Outpatient	$35 copay / $60 copay
Physical Therapy	20% after deductible
Occupational, Speech Therapy	$35 copay

PHARMACY PLAN

$0 RX Deductible	
Preferred Generic Drugs	$0
Non-Preferred Generic Drugs	$25
Preferred Brand Drugs	$50
Non-Preferred Brand Drugs	$125
Specialty Drugs	$150

**COVERAGE SHOWN FOR IN-NETWORK TREATMENT*

DIRECT PRIMARY CARE HIGH PERFORMANCE

CONCIERGE-SERVICE, HIGH DEDUCTIBLE HEALTH PLAN WITH PRIMARY HEALTH PARTNERS **(PHP)** AND THE ZERO CARD

Calendar Year Deductible and Out-Of-Pocket Maximum	$6,000 Ind. / $12,000 Family
Teladoc Mental Health Therapist	$25 copay

DIRECT PRIMARY CARE AND AETNA INFORMATION

- Relationship-based, primary healthcare doctors available 24/7 for patients.
- Patients choose a doctor, form a relationship and can receive diagnostic, preventative, and pharmacy services from one location, included in the cost of their monthly premium.
- PHP caps 750 patients per doctor, allowing for same-day and next-day service for all medical needs.
- Aetna Insurance can be used, but PHP will never bill employee's insurance.
- Mental health copays are included: $25 in-office/$15 virtual

- A pharmacy is available on-site.
- PHP guides patients on cash pricing, service pricing and provides most services in-house.
- An HSA is not included on this plan, but The Zero Card Benefit is included.
- PHP offers hormone replacement therapy, allergy testing (with blood draws), weight management, and can call in prescriptions without seeing their patients if a suitable relationship is established.
- In emergent cases, like hospitalization, Aetna will be billed.

PHARMACY AND TESTING INFORMATION

- Affordable, generic medications are available on-site for patients at their preferred clinic.
- For prescriptions that are not available on-site, a script may be picked up at any in-network pharmacy,
- Doctors will counsel patients on cash pricing, using the GoodRx app, and may call in prescriptions without any appointment needed.

$0 RX Deductible	
Preferred Generic Drugs	$0
Non-Preferred Generic Drugs	$40
Preferred Brand Drugs	$75
Non-Preferred Brand Drugs	Deductible and Coinsurance
Specialty Drugs	Deductible and Coinsurance

**COVERAGE SHOWN FOR IN-NETWORK TREATMENT*

PRIMARY-HEALTHPARTNERS.COM

HDHP WITH HSA BROAD

HIGH DEDUCTIBLE HEALTH PLAN WITH UCO HSA CONTRIBUTION

Calendar Year Deductible	$3,000 Ind. / $9,000 Family
Calendar Year Out-Of-Pocket Maximum	$6,500 Ind. / $10,000 Family
Coinsurance	20% after deductible
Office Visit	20% after deductible
Specialist Visit	20% after deductible
Teladoc Visit/ Teladoc Dermatology	20% after deductible
Teladoc LPC/ Teladoc Pyschiatrist	20% after deductible
Preventative Services	100%
Emergency Room	$250 copay, then 20% after deductible Copay waived if admitted
Mental Health Inpatient	20% after deductible
Mental Health Outpatient	20% after deductible
Physical, Speech and Occupational Therapy	20% after deductible

PHARMACY PLAN

$0 RX Deductible	
Preferred Generic Drugs	20% after deductible
Non-Preferred Generic Drugs	20% after deductible
Preferred Brand Drugs	20% after deductible
Non-Preferred Brand Drugs	20% after deductible
Specialty Drugs	20% after deductible

**COVERAGE SHOWN FOR IN-NETWORK TREATMENT*