

MEDICAL PLAN

OPTION 1: HMO COPAY PLAN

Please Note: you have two medical plan options to choose from. Your first option is an HMO. An HMO gives you access to certain doctors and hospitals within its network. A network is made up of providers that have agreed to lower their rates for plan members and also meet quality standards. You do not have out-of-network coverage. Below is a high-level overview of your benefit options.

Prevea360	In-Network	Out-of-Network
Deductible		
Single	\$1,000	N/A
Family	\$2,000	N/A
HRA	1 st \$375: Employee 2 nd \$625: HRA	N/A N/A
Out-of-Pocket Maximum		
Single	\$6,850	N/A
Family	\$13,700	N/A
Coinsurance	100%	N/A
Dependent Eligibility	To Age 26 (end of month)	
PHYSICIAN SERVICES		
Select Preventative Services	Covered In Full	Not Covered
Primary Care Office Visit	\$10 Copay	Not Covered
Specialty Care Office Visit	\$10 Copay	Not Covered
Partnered Health Location	\$5 Copay	N/A
HOSPITAL SERVICES		
Inpatient / Outpatient	Deductible	Not Covered
URGENT CARE & ER SERVICES		
Urgent Care	\$10 Copay, then Deductible	\$10 Copay, then In-Network Deductible
Emergency Care	\$100 Copay, then Deductible (Copay is waived if admitted)	\$100 Copay, then In-Network Deductible (Copay is waived if admitted)
RETAIL PRESCRIPTION DRUGS		
Tier 1	\$10 Copay	Not Covered
Tier 2	\$25 Copay	Not Covered
Tier 3	\$50 Copay	Not Covered
Tier 4	Not Covered	Not Covered

\$0 Preventive Rx List and Prevea Partnered Health Included

Please reference page (177) for premium information.

MEDICAL PLAN (continued)

OPTION 2: POS COPAY PLAN

Your second option is a Point of Service (POS) option. This option also gives you access to certain doctors and hospitals within its network, as well as coverage for doctors and hospitals outside of the network. Out of network services will be processed at the out of network coverage level noted below. Below is a high-level overview of your benefit options.

Prevea360	In-Network	Out-of-Network
Deductible		
Single	\$1,000	\$1,500
Family	\$2,000	\$3,000
HRA	1st \$375: Employee 2nd \$625: HRA	1 st \$500: Employee 2 nd \$1,000: HRA
Out-of-Pocket Maximum		
Single	\$6,850	\$2,750
Family	\$13,700	\$5,500
Coinsurance	100%	80%
Dependent Eligibility To Age 26 (end of month)		
PHYSICIAN SERVICES		
Select Preventative Services	Covered In Full	Deductible & Coinsurance
Primary Care Office Visit	\$10 Copay	Deductible & Coinsurance
Specialty Care Office Visit	\$10 Copay	Deductible & Coinsurance
Partnered Health Location	\$5 Copay	N/A
HOSPITAL SERVICES		
Inpatient / Outpatient	Deductible	Deductible & Coinsurance
URGENT CARE & ER SERVICES		
	In-Network	Out-of-Network
Urgent Care	\$10 Copay, then Deductible	\$10 Copay, then In-Network Deductible
Emergency Care	\$100 Copay, then Deductible (Copay waived if admitted)	\$100 Copay, then In-Network Deductible (Copay waived if admitted)
RETAIL PRESCRIPTION DRUGS		
Tier 1	\$10 Copay	50% Coinsurance
Tier 2	\$25 Copay	50% Coinsurance
Tier 3	\$50 Copay	50% Coinsurance
Tier 4	Not Covered	Not Covered

\$0 Preventive Rx List and Prevea Partnered Health Included

Please reference page (17) for premium information.