PREVEA360 health plan
centered around you

SCHOOL DISTRICT OF SEVASTOPOL

Effective Date: 07/01/2021

Plan 1 - 0

Product Type: Network

Plan Code: HMO05495/PHA02200

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$1,000 single / 2000 family	Not Covered
Coinsurance	0% coinsurance after deductible	Not Covered
Office Visit Charge (Primary/Specialist)	$20 copay	Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	$0 copay	Not Covered
Deductible and Coinsurance Limit	$1,000 single / $2,000 family	Not Covered
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$6,850 single / $13,700 family	Not Covered
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	$20 copay	Not Covered
Tier 2	$40 copay	Not Covered
Tier 3	$60 copay	Not Covered
Tier 4	Not Covered	Not Covered
Tier 5	Not Covered	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	$0 copay / $0 copay	Not Covered / Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered
Emergency Services		
Urgent Care	$20 copay and/or 0%coinsurance after deductible	$20 copay and/or 0%coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$200 copay and/or 0%coinsurance after deductible	$200 copay and/or 0%coinsurance after In-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	$20 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	$20 copay per therapy type per day	Not Covered
Plan Special Features	INCLUDES PREVEA PARTNERED HEALTH BENEFIT.	

This renewal plan includes prescription drug coverage that is creditable
Unless otherwise noted, all benefits are based on a Calender Year
This benefit summary is a highlight of your benefits and should not be relied upon to fully disclose
Please review your Member Certificate of Coverage for an exact description of the services and supplies that are covered, excluded, or limited and other terms and conditions of coverage. Your Member Certificate is available at www.prevea360.com.

Date Prepared: 03/02/21

PREVEA360 health plan
centered around you

SCHOOL DISTRICT OF SEVASTOPOL

Effective Date: 07/01/2021

Plan 2 - 0

Product Type: POS

Plan Code: POS04294/PHA02201

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$1,000 single / 2000 family	$1,500 single / $3,000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	$20 copay	20% coinsurance after deductible
Office Visit and Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Preventive Services	$0 copay	$0 copay and/or 20% coinsurance after deductible
Deductible and Coinsurance Limit	$1,000 single / $2,000 family	Not Applicable
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$6,850 single / $13,700 family	$2,750 single / $5,500 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	$20 copay	50% coinsurance
Tier 2	$40 copay	50% coinsurance
Tier 3	$60 copay	Not Covered
Tier 4	Not Covered	Not Covered
Tier 5	Not Covered	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	$0 copay / $0 copay	20% coinsurance after deductible / 20% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		
Urgent Care	$20 copay and/or 0% coinsurance after deductible	$20 copay and/or 0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$200 copay and/or 0% coinsurance after deductible	$200 copay and/or 0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Day Treatment Programs	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Outpatient	$20 copay	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	$20 copay per therapy type per day	20% coinsurance after deductible
Plan Special Features	INCLUDES PREVEA PARTNERED HEALTH BENEFIT.	

This renewal plan includes prescription drug coverage that is creditable
Unless otherwise noted, all benefits are based on a Calendar Year
This benefit summary is a highlight of your benefits and should not be relied upon to fully disclose
Please review your Member Certificate of Coverage for an exact description of the services and supplies that are covered, excluded, or limited and other terms and conditions of coverage. Your Member Certificate is available at www.prevea360.com.

Date Prepared: 03/02/21