

SCHOOL DISTRICT OF SEVASTOPOL

Effective Date: 07/01/2021

Product Type: Network

Plan Code: HMO05495/PHA02200

Emergency Room Services (Copay is waived if admitted) \$200 copay and/or 0%coinsurance after deductible \$200 copay and/or 0%coinsurance after deductible 0% coinsurance after deductible Officer 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 Not Covered Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered			
Coinsurance Office Visit Charge (Primary/Specialist) S20 copay Not Covered Office Visit and Related Services S50 copay Not Covered Not Covered S1,000 eingle / \$2,000 family Not Covered Deductible and Coinsurance Limit Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Maximum Out-of-Pocket (Deductible and Coinsurance and Limit plus Tier 1 \$20 copay Not Covered Vinless otherwise Indicated, parints or prant anam exque an be found in an office of the Covered Vinless otherwise Indicated, parints or prant anam exque an be found in an office and control of the Covered Vinless otherwise Indicated, parints or prant anam exque an be found in an office and control of the Covered Vinless otherwise Indicated, parints or prant anam exques an be found in an office and control of the Covered Vinless otherwise Indicated, parints or prant anam exquest and control of the Covered Vinless otherwise Indicated, parints or prant anam exquest and control of the Covered Vinless otherwise Indicated, parints or prant an anam exquest and control of the Covered Not Covered Not Covered Not Covered Not Covered Not Covered Vinless otherwise Indicated, parints or prant anam exquest and control of the Covered Not Co	Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Office Visit Charge (Primary/Specialist) \$20 copey Not Covered Not Covered Not Covered Not Covered \$0 copey Not Covered Not Covered Not Covered Not Covered Not Covered \$0 copey Not Covered Not Covere	Deductible	\$1,000 single / 2000 family	Not Covered
Office Visit and Related Services Office Visit and Related Services So copay Not Covered Not Covered Not Covered Not Covered So copay Not Covered Not Covered Not Covered So copay Not Covered Not Covered Not Covered Not Covered Tier 1 So copay Not Covered	Coinsurance	0% coinsurance after deductible	Not Covered
Preventive Services \$ 0 copay Not Covered Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Strapplies Tier 1 \$ 20 copay Not Covered Tier 2 \$ 40 copay Not Covered Tier 3 \$ 60 copay Not Covered Tier 4 Not Covered Not Covered Not Covered Tier 5 Not Covered	Office Visit Charge (Primary/Specialist)	\$20 copay	Not Covered
Deductible and Coinsurance Limit S1,000 single / \$2,000 family Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 S20 copay Not Covered Tier 2 \$40 copay Not Covered Tier 3 \$60 copay Not Covered Tier 4 Not Covered Not Covered Not Covered Tier 5 Not Covered	Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$20 copay Not Covered Tier 2 \$40 copay Not Covered Tier 3 \$60 copay Not Covered Tier 4 Not Covered Not Covered Not Covered Tier 5 Not Covered Not Covered Not Covered Tier 5 Not Covered Not Covered Not Covered Not Covered Tier 6 Not Covered Not Covered Not Covered Not Covered Not Covered Tier 7 Not Covered	Preventive Services	\$0 copay	Not Covered
Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$20 copay Not Covered Tier 2 \$40 copay Not Covered	Deductible and Coinsurance Limit	\$1,000 single / \$2,000 family	Not Covered
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 Tier 5 Not Covered Not Covered Disgnostic Services Diagnostic Services (Xrays/Labs) \$0 copay / \$0 copay Not Covered Total Covered Not Covered Not Covered Not Covered Not Covered Not Covered Disgnostic Services (Xrays/Labs) \$0 copay / \$0 copay Not Covered Tier 5 Not Covered Not Covered Not Covered Not Covered Office Consumance after deductible Not Covered Not Covered Office Consumance after deductible Not Covered Tier 5 Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered S20 copay and/or Officionsumance after deductible S20 copay and/or Officionsumance after deductible Tier 5 Not Covered Not Covered S20 copay and/or Officionsumance after deductible Not Covered		\$6,850 single / \$13,700 family	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 Diagnostic Services (Xrays/Labs) \$0 copay / \$0 copay Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Toer 5 Not Covered Not Covered Not Covered S20 copay and/or 0%coinsurance after deductible Not Covered S20 copay and/or 0%coinsurance after deductible Not Covered Not Covered Not Covered Not Covered Not	Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or formula	brand name drugs can be found in any ary tier)
Tier 3 \$60 copsy Not Covered Tier 4 Not Covered Not Covered Tier 5 Not Covered Not Covered S20 copsy and/or O%coinsurance after deductible Not Covered S20 copsy and/or O%coinsurance after deductible Not Covered	Tier 1	\$20 copay	Not Covered
Tier 4 Not Covered Not Covered Not Covered Not Covered Piagnostic Services Diagnostic Services (Xrays/Labs) \$0 copsy / \$0 copsy Not Covered Not Covered Phospital & Surgical Center Inpatient Hospital & Surgical Center Urgent Care \$20 copsy and/or 0%coinsurance after deductible Not Covered Piagnosty Services Urgent Care \$20 copsy and/or 0%coinsurance after deductible Remergency Services (Copsy is waived if admitted) \$200 copsy and/or 0%coinsurance after deductible Remergency Room Services (Copsy is waived if admitted) \$200 copsy and/or 0%coinsurance after deductible Other Services Wental Health Inpatient 0% coinsurance after deductible Not Covered Physical, Speech & Occupational Therapy \$20 copsy per therapy type per day Not Covered Physical, Speech & Occupational Therapy \$20 copsy per therapy type per day Not Covered Not Covered Physical, Speech & Occupational Therapy \$20 copsy per therapy type per day Not Covered Not Covered Physical, Speech & Occupational Therapy	Tier 2	\$40 copay	Not Covered
Tier 5 Not Covered	Tier 3	\$60 copay	Not Covered
Diagnostic Services Diagnostic Services (Xrays/Labs) \$0 copay / \$0 copay Not Covered / Not Covered Emergency Services Urgent Care \$20 copay and/or 0%coinsurance after deductible Emergency Room Services (Copay is waived if admitted) \$200 copay and/or 0%coinsurance after deductible Emergency Room Services (Copay is waived if admitted) Ambulance O% coinsurance after deductible O% coinsurance after deductible O% coinsurance after deductible Not Covered	Tier 4	Not Covered	Not Covered
Diagnostic Services (Xrays/Labs) \$0 copay / \$0 copay Not Covered / Not Covered Semergency Services Urgent Care \$20 copay and/or 0%coinsurance after deductible \$20 copay and/or 0%coinsurance after network deductible Semergency Room Services (Copay is waived if admitted) Not Covered	Tier 5	Not Covered	Not Covered
CAT Scans/MRI/MRA O% coinsurance after deductible Not Covered	Diagnostic Services		
Hospital & Surgical Center Inpatient Hospital Ow coinsurance after deductible Not Covered Outpatient Hospital Ow coinsurance after deductible Not Covered Emergency Services Urgent Care \$20 copay and/or 0%coinsurance after deductible Emergency Room Services (Copay is waived if admitted) Ambulance Ow coinsurance after deductible Not Covered Mental Health Inpatient Ow coinsurance after deductible Not Covered Mental Health Outpatient Ow coinsurance after deductible Ow coinsurance after deductible Not Covered Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered	Diagnostic Services (Xrays/Labs)	\$0 copay / \$0 copay	Not Covered / Not Covered
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 network deductible Emergency Room Services (Copay is waived if admitted) \$200 copay and/or 0%coinsurance after deductible of network deductible Emergency Room Services (Copay is waived if admitted) \$200 copay and/or 0%coinsurance after deductible of network deductible Ambulance 0% coinsurance after deductible 0% coinsurance after deductible of network deduct	CAT Scans/MRI/MRA	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 network deductible Emergency Room Services (Copay is waived if admitted) \$200 copay and/or 0% coinsurance after deductible Not Covered Mental Health Inpatient 0% coinsurance after deductible Not Covered Mental Health Outpatient \$20 copay 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	Hospital & Surgical Center	THE RESIDENCE OF A STREET	
Emergency Services Urgent Care \$20 copay and/or 0%coinsurance after deductible Emergency Room Services (Copay is waived if admitted) Ambulance O% coinsurance after deductible Not Covered Mental Health Day Treatment Programs O% coinsurance after deductible Not Covered Mental Health Outpatient \$20 copay and/or 0%coinsurance after deductible O% coinsurance after deductible O% coinsurance after deductible Not Covered Not Covered Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered	Inpatient Hospital	0% coinsurance after deductible	Not Covered
Urgent Care \$20 copay and/or 0%coinsurance after deductible Emergency Room Services (Copay is waived if admitted) \$200 copay and/or 0%coinsurance after deductible \$200 copay and/or 0%coinsurance after deductible \$200 copay and/or 0%coinsurance after deductible 0% coinsurance after deductible 0% coinsurance after deductible Not Covered Mental Health Day Treatment Programs Mental Health Outpatient \$200 copay and/or 0%coinsurance after deductible 0% coinsurance after deductible Not Covered Not Covered Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered	Outpatient Hospital	0% coinsurance after deductible	Not Covered
Urgent Care deductible network deductible	Emergency Services		
Emergency Room Services (Copay is waived if admitted) Ambulance Other Services Mental Health Inpatient Mental Health Day Treatment Programs Mental Health Outpatient Ow coinsurance after deductible Not Covered Mental Health Outpatient Services Mental Health Day Treatment Programs Ow coinsurance after deductible Not Covered Mental Health Outpatient Services Mental Health Day Treatment Programs Ow coinsurance after deductible Not Covered Not Covered Physical, Speech & Occupational Therapy Services Not Covered Not Covered Not Covered Not Covered	Urgent Care		\$20 copay and/or 0%coinsurance after in- network deductible
Other Services Mental Health Inpatient Mental Health Day Treatment Programs Mental Health Outpatient Mental Health Outpatient Mental Health Outpatient Services Mental Health Day Treatment Programs Mental Health Outpatient Services Mental Health Outpatient Services Mental Health Day Treatment Programs Mot Covered Not Covered Physical, Speech & Occupational Therapy Services Services Mental Health Inpatient Services Mot Covered Not Covered Not Covered Not Covered Not Covered	Emergency Room Services (Copay is waived if admitted)		\$200 copay and/or 0%coinsurance after in network deductible
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	Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Mental Health Day Treatment Programs 0% coinsurance after deductible Not Covered Not Covered Not Covered Not Covered Not Covered Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered	Other Services	是自由的生产研究的企业的主义	
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	Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Durable Medical Equipment 0% coinsurance after deductible Not Covered Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered	Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy \$20 copay per therapy type per day Not Covered	Mental Health Outpatient	\$20 copay	Not Covered
Thysical, operating occupational morapy	Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Plan Special Features INCLUDES PREVEA PARTNERED HEALTH BENEFIT	Physical, Speech & Occupational Therapy	\$20 copay per therapy type per day	Not Covered
rian opecial restures	Plan Special Features	INCLUDES PREVEA PARTNERED HEALTH BENEFIT.	



SCHOOL DISTRICT OF SEVASTOPOL

Effective Date: 07/01/2021

Product Type: POS
Plan Code: POS04294/PHA02201

Plan Overview	Plan Providers - You Pay	Noп-Plan Providers - You Pay
Deductible	\$1,000 single / 2000 famlly	\$1,500 single / \$3,000 famlly
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 formula	
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	THE RESERVE STONE OF THE PARTY.	ATT WALLES AND A CONTROL OF
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% colnsurance after deductible	20% colnsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		经的民族系统的特殊的特殊的
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% colnsurance after deductible	\$200 copay and/or 0% coinsurance after in- network deductible
Ambulance	0% colnsurance after deductible	0% coinsurance after in-network deductible
Other Services	是给我们是为他是不是的比较	TANK SUMMARKAN PROMISE TO AND THE
Mental Health Inpatient	0% coinsurance after deductible	20% colnsurance after deductible
Mental Health Day Treatment Programs	0% colnsurance after deductible	20% colnsurance after deductible
Mental Health Outpatient	\$20 copay	20% colnsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% colnsurance 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.	