Medical Plan Options

(summary only - see plan description for additional information regarding coverage and limitations)

Plan Provisions	Prevea Health and Wellness Center	Standard PPO		Health Savings Plan	
		In-Network	Out of Network	In-Network	Out of Network
Annual Deductible* (Individual/Family) * deductible must be met before plan pays for covered services	None	$2,000/$4,000	$6,000/$12,000	$4,000/$8,000	$12,000/$24,000
Out of Pocket Maximum (includes deductibles and copays)	None	$6,350/$12,700	$19,050/$38,100	$6,350/$12,700	$19,050/$38,100
Lifetime Maximum	Unlimited	Unlimited		Unlimited	
Prescription Drugs	Not Covered				
Deductible		$250/$500	$750/$1,500	Included in Annual Deductible	
Copay (Level 1, 2, 3)		$10/$40/$70	$10/$40/$70	$0.00	$0.00
Coinsurance (after deductible)		None	30%	20%	50%
Preventive Care/Immunizations	Covered 100%	Covered 100%	30% coinsurance	Covered 100%	50% coinsurance
Primary care to treat illness or minor injury	Covered 100%	$40 Copay	30% coinsurance	20% coinsurance	50% coinsurance
Physical Therapy	Covered 100%	$70 Copay	30% coinsurance	20% coinsurance	50% coinsurance
Chiropractic Care	$20 Copay	$70 Copay	30% coinsurance	20% coinsurance	50% coinsurance
Diagnostic Test	Lab: Covered 100% X-ray: Billed to Medical Plan	Covered 100%	30% coinsurance	20% coinsurance	50% coinsurance
Outpatient Hospital Services	Not Available	40% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care	Covered 100%	$100 copay	30% coinsurance	20% coinsurance	50% coinsurance
Emergency Room	Not Available	$500 copay (waived if admitted)	$500 copay (waived if admitted)	20% coinsurance	20% coinsurance
Inpatient Hospital Stay	Not Available	40% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance