

# Prevea360 Health Plan

VANS LUMBER &amp; CUSTOM BUILDERS

Product Type: Network

Effective Date: 01/01/2021

Plan Code: HMO05111/PHA02411

Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$3000 single / \$6000 family	N/A
Coinsurance	20% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	\$50 copay / \$90 copay	Not Covered / Not Covered
Office Visit and Related Services	20% coinsurance after deductible	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible and Coinsurance Limit	N/A	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$7150 single / \$14300 family	N/A
<b>Prescription Drugs, Insulin &amp; Disposable Diabetic Supplies</b>	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	\$15 copay	Not Covered
Tier 2	\$60 copay	Not Covered
Tier 3	\$120 copay	Not Covered
Tier 4	\$150 copay	Not Covered
Tier 5	\$200 copay	Not Covered
<b>Diagnostic Services</b>		
Diagnostic Services	20% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	20% coinsurance after deductible	Not Covered
<b>Hospital &amp; Surgical Center</b>		
Inpatient Hospital	20% coinsurance after deductible	Not Covered
Outpatient Hospital	20% coinsurance after deductible	Not Covered
<b>Emergency Services</b>		
Urgent Care	\$90 copay and/or 20% coinsurance after deductible	\$90 copay and/or 20% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible
<b>Other Services</b>		
Mental Health Inpatient	20% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	20% coinsurance after deductible	Not Covered
Mental Health Outpatient	\$50 copay	Not Covered
Durable Medical Equipment	20% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	\$90 copay per therapy type per day	Not Covered
<b>Plan Special Features</b>		

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 your coverage.  
 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](http://www.prevea360.com).