2025 Prevea Health Medical Plans Available to Employees

Below is a brief outline of the medical plan designs offered to eligible employees. Please refer to the Health Insurance information on Prevea.com/employees or the Summary Plan Description (SPD) located on the myADP for complete plan details. The percentages in the following grid are the percentages the plan pays.

Plan Highlights	HDHP High EPO Plan (HSA Qualified) No Out-of-Network Coverage	HDHP EPO Plan (HSA Qualified) No Out-of-Network Coverage	Traditional EPO Plan (non Qualified HSA) No Out-of-Network Coverage	HDHP PPO Plan (HSA Qualifed) Out of Area Participants Only Please See Zip Code List for Eligibility	
Benefits Coverage	In-Network	In-Network	In-Network	In-Network	Out-of-Network
Annual Deductible					
Individual	$5,000	$2,000	$1,000	$2,000	$4,000
EE +1	$10,000 ($5,000 per Individual)	$4,000 Combined	$2,000 ($1,000 per Individual)	$4,000 Combined	$8,000 Combined
Family	$10,000 ($5,000 per Individual)	$4,000 Combined	$2,000 ($1,000 per Individual)	$4,000 Combined	$8,000 Combined
Coinsurance	100%	80%	80%	80%	60%
Annual Maximum Out-of-Pocket Amount					
Individual	$5,000	$3,000	$3,000	$3,000	$6,000
Family	$10,000	$6,000	$6,000	$6,000	$12,000
Additional Coverage Details					
Primary Care	100% after Deductible	80% after Deductible	Office Visit: $25 Copay All Other Services: 80% after Deductible	80% after Deductible	60% after Deductible
Physical & Occupational Therapy	100% after Deductible	80% after Deductible	Office Visit: $25 Copay All Other Services: 80% after Deductible	80% after Deductible	60% after Deductible
Specialty Care	100% after Deductible	80% after Deductible	Office Visit: $50 copay All Other Services: 80% after Deductible	80% after Deductible	60% after Deductible
Urgent Care	100% after Deductible	80% after Deductible	Prevea Virtual Care: $15 Copay Prevea Urgent Care: $25 Copay	80% after Deductible	80% after Deductible
Emergency Room	100% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible	
Adult Preventive Exams & Well-Child Care	100%	100%	100%	100%	60% after Deductible
Immunizations	100% after Deductible (as applicable)	80% after Deductible (as applicable)	80% after Deductible (as applicable)	80% after Deductible	60% after Deductible
Labs	100% after Deductible (as applicable)	80% after Deductible (as applicable)	80% after Deductible (as applicable)	80% after Deductible	60% after Deductible
X-ray, Radiology	100% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible	60% after Deductible
Inpatient Charges	100% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible	60% after Deductible
Outpatient and Surgical Charges	100% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible	60% after Deductible

Pharmacy Benefits – ***Note:*** *Plan member prescription out-of-pocket amounts track toward the annual deductible and annual out-of-pocket amounts for the HDHP Plan designs. Plan member prescription co-payments that apply to the Traditional Plan design track toward the annual out-of-pocket amount only (and not the annual deductible amount).*					
Retail Pharmacy (30 Day Supply or up to 90 day Supply for maintenance medications) ACA/Preventive Drug List applies to HDHP plan options* See plan for details					
Generic (Tier 1)	100% after Deductible	80% after Deductible	$5 Copay	80% after Deductible	Not Covered
Preferred Brand (Tier 2)	100% after Deductible	80% after Deductible	$25 Copay	80% after Deductible	Not Covered
Non-Preferred Brand (Tier 3)	100% after Deductible	80% after Deductible	$40 Copay, then 80%	80% after Deductible	Not Covered
Preferred Specialty (Tier 4)	100% after Deductible	80% after Deductible	80%	80% after Deductible	Not Covered
Mail Order Pharmacy (90 Day Supply) ACA/Preventive Drug List applies to HDHP plan options* See plan for details					
Generic (Tier 1)	100% after Deductible	80% after Deductible	$12.50 Copay	80% after Deductible	Not Covered
Preferred Brand (Tier 2)	100% after Deductible	80% after Deductible	$62.50 Copay	80% after Deductible	Not Covered
Non-Preferred Brand (Tier 3)	100% after Deductible	80% after Deductible	$100 Copay, then 80%	80% after Deductible	Not Covered
Preferred Specialty[1] (Tier 4)	100% after Deductible	80% after Deductible	80%	80% after Deductible	Not Covered
[1] If covered specialty medications are arranged through CVS/Caremark **PrudentRx Copay Program**, $0 out-of-pocket costs will apply. Please refer to the Health Insurance information on Prevea.com/employees or the Summary Plan Description (SPD) located on the ADP portal for complete plan details.					

2025 Medical Plan Employee Contributions (Bi- Weekly)		
HDHP High EPO Plan (HSA Qualified)	Full-Time	Part-Time
Employee	$48.27	$144.81
Employee +1	$99.55	$298.66
Family	$132.84	$398.53
HDHP EPO Plan (HSA Qualified)	Full-Time	Part-Time
Employee	$68.35	$155.55
Employee +1	$140.96	$320.80
Family	$188.09	$428.07
Traditional EPO Plan (non-Qualifed HSA)	Full-Time	Part-Time
Employee	$111.85	$198.85
Employee +1	$231.33	$411.26
Family	$308.82	$549.01
HDHP PPO Plan (Out of Area Only)	Full-Time	Part-Time
Employee	$68.35	$155.55
Employee +1	$140.96	$320.80
Family	$188.09	$428.07