

## 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](https://prevea.com/employees) or the Summary Plan Description (SPD) located on the myADP for complete plan details.

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 Qualified) Out of Area Participants Only Please See Zip Code List for Eligibility	
<b>Benefits Coverage</b>	In-Network	In-Network	In-Network	In-Network	Out-of-Network
<b>Annual Deductible</b>					
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%
<b>Annual Maximum Out-of-Pocket Amount</b>					
Individual	\$5,000	\$3,000	\$3,000	\$3,000	\$6,000
Family	\$10,000	\$6,000	\$6,000	\$6,000	\$12,000
<b>Additional Coverage Details</b>					
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	20% after Deductible	\$5 Copay	20% after Deductible	Not Covered
Preferred Brand (Tier 2)	100% after Deductible	20% after Deductible	\$25 Copay	20% after Deductible	Not Covered
Non-Preferred Brand (Tier 3)	100% after Deductible	20% after Deductible	\$40 Copay, then 20%	20% after Deductible	Not Covered
Preferred Specialty (Tier 4)	100% after Deductible	20% after Deductible	20%	20% 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	20% after Deductible	\$12.50 Copay	20% after Deductible	Not Covered
Preferred Brand (Tier 2)	100% after Deductible	20% after Deductible	\$62.50 Copay	20% after Deductible	Not Covered
Non-Preferred Brand (Tier 3)	100% after Deductible	20% after Deductible	\$100 Copay, then 20%	20% after Deductible	Not Covered
Preferred Specialty <sup>1</sup> (Tier 4)	100% after Deductible	20% after Deductible	20%	20% after Deductible	Not Covered

<sup>1</sup> 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-Qualified 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