

2024 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 ADP portal for complete plan details. Provisions noted with an asterisk (*) refer to Prevea's **Partnered Health** program— Please refer to the Prevea Partnered Health Handouts for detailed information on Discounts, eligible services, and eligible locations.

Plan Highlights	Dean Health Plan, Inc. HDHP EPO Plan (HSA Qualified) <i>*Prevea Partnered Health (PPH) Discount Eligible</i>		Dean Health Plan, Inc. Traditional EPO Plan (non Qualified HSA) <i>*Prevea Partnered Health (PPH) Visit Co-pay/Discount Eligible</i>		Dean Health Plan, Inc. HDHP PPO Plan (HSA Qualified) Out of Area Participants Only - Please see zip code list for eligibility <i>Prevea Partnered Health (PPH) : Not Eligible</i>	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefits Coverage						
Annual Deductible						
Individual	\$2,000	Not covered	\$1,000	Not covered	\$2,000	\$4,000
EE +1	\$4,000 combined	Not covered	\$2,000 individual	Not covered	\$4,000 combined	\$8,000 combined
Family	\$4,000 combined	Not covered	\$2,000 individual	Not covered	\$4,000 combined	\$8,000 combined
Coinsurance	80%	Not covered	80%	Not covered	80%	60%
Annual Maximum Out-of-Pocket Amount						
Individual	\$3,000	Not covered	\$2,000	Not covered	\$3,000	\$6,000
Family	\$6,000	Not covered	\$4,000	Not covered	\$6,000	\$12,000
Additional Coverage Details						
Primary Care	<i>*80% after deductible</i>	Not covered	Office Visit: <i>*\$25 copay</i> All other services 80% after deductible	Not covered	80% after deductible	60% after deductible
Physical & Occupational Therapy	<i>*80% after deductible</i>	Not covered	Office Visit: <i>*\$25 copay</i> All other services 80% after deductible	Not covered	80% after deductible	60% after deductible
Specialty Care	80% after deductible	Not covered	Office Visit: \$50 copay All other services 80% after deductible	Not covered	80% after deductible	60% after deductible
Urgent Care	<i>*80% after deductible</i>	Not covered	\$15 Prevea Virtual Care <i>*\$25 Prevea Urgent Care</i>	Not covered	80% after deductible	80% after deductible
Emergency Room	80% after deductible		80% after deductible		80% after deductible	
Adult Periodic Exams & Well-Child Care	100%	Not covered	100%	Not covered	100%	60% after deductible

Plan Highlights	Dean Health Plan, Inc. HDHP EPO Plan (HSA Qualified) <i>*Prevea Partnered Health (PPH) Discount Eligible</i>		Dean Health Plan, Inc. Traditional EPO Plan (non Qualified HSA) <i>*Prevea Partnered Health (PPH) Visit Co-pay/Discount Eligible</i>		Dean Health Plan, Inc. HDHP PPO Plan (HSA Qualified) Out of Area Participants Only - Please see zip code list for eligibility <i>Prevea Partnered Health (PPH) : Not Eligible</i>	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Immunizations	<i>*80% after deductible (as applicable)</i>	Not covered	<i>*80% after deductible (as applicable)</i>	Not covered	80% after deductible	60% after deductible
Labs	<i>*80% after deductible (as applicable)</i>	Not covered	<i>*80% after deductible (as applicable)</i>	Not covered	80% after deductible	60% after deductible
X-ray, Radiology	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	60% after deductible
Inpatient Charges	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	60% after deductible
Outpatient and Surgical Charges	80% after deductible	Not covered	80% after deductible	Not covered	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)	20% after deductible	Not covered	\$5 copay	Not covered	20% after deductible	Not covered
Preferred Brand (Tier 2)	20% after deductible	Not covered	\$25 copay	Not covered	20% after deductible	Not covered
Non-Preferred Brand (Tier 3)	20% after deductible	Not covered	\$40 copay, then 20%	Not covered	20% after deductible	Not covered
Preferred Specialty (Tier 4)	20% after deductible	Not covered	20%	Not covered	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)	20% after deductible	Not covered	\$12.50 copay	Not covered	20% after deductible	Not covered
Preferred Brande (Tier 2)	20% after deductible	Not covered	\$62.50 copay	Not covered	20% after deductible	Not covered
Non-Preferred Brand (Tier 3)	20% after deductible	Not covered	\$100 copay, then 20%	Not covered	20% after deductible	Not covered
Preferred Specialty ¹ (Tier 4)	20% after deductible	Not covered	20%	Not covered	20% after deductible	Not covered

¹If 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.

2024 Medical Plan Employee Contributions (Bi- Weekly)		
HDHP EPO Plan (HSA Qualified)	Full-Time	Part-time
Employee	\$73.71	\$151.51
Employee +1	\$152.01	\$312.47
Family	\$202.84	\$416.95
Traditional EPO Plan (non-Qualified HSA)	Full-Time	Part-time
Employee	\$106.20	\$190.27
Employee +1	\$219.64	\$393.51
Family	\$293.20	\$525.32
HDHP PPO Plan (Out of Area Only)	Full-Time	Part-time
Employee	\$73.71	\$151.51
Employee +1	\$152.01	\$312.47
Family	\$202.84	\$416.95

Spouse Medical Insurance Fee: If your spouse has other full-time medical insurance coverage available through their employer, they must take at least single coverage through their employer to serve as primary coverage, or there is an additional fee (\$57.69 per pay period) to enroll spouse in Prevea’s medical coverage as primary coverage. See the Spouse Medical Insurance Coverage statement at Prevea.com/employees. **This form is required if your spouse is enrolled in Prevea’s medical plan.**

PCP Engagement Surcharge: A \$50 per month surcharge will be added to the above premiums for each eligible employee that does not complete proof of participation (see additional details on p. 9 of this guide).

- *HDHP/HSA PPH Discount: See PPH- HDHP EPO Plan Flyer for discounts and plan details
- *Traditional PPH Copays/Discounts: See PPH- Traditional EPO Plan Flyer for discounts and plan details