HMO

Plan 1 - 0

Prevea360 Health Plan

SCHOOL DISTRICT OF KOHLER

Effective Date: 07/01/2020

Product Type: Network

Plan Code: HMO04841/PHA02212

Plan Overview	In Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$2000 single / $4000 family	N/A
Coinsurance	0% coinsurance after deductible	N/A
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible / 0% coinsurance after deductible	Not Covered / Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	$0 copay	Not Covered
Deductible and Coinsurance Limit	$2000 single / $4000 family	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$4000 single / $8000 family	N/A
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier	
Tier 1	$20 copay	Not Covered
Tier 2	$45 copay	Not Covered
Tier 3	$70 copay	Not Covered
Tier 4	$100 copay	Not Covered
Tier 5	$200 copay	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered
Emergency Services		
Urgent Care	0% coinsurance after deductible	0% coinsurance after deductible
Emergency Room Services (Copay is waived if admitted)	$300 copay and/or 0% coinsurance after deductible	$300 copay and/or 0% coinsurance after deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	0% coinsurance after deductible	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	Not Covered
Plan Special Features	Plan administered on a Contract Year basis	

This renewal plan includes prescription drug coverage that is creditable
Unless otherwise noted, all benefits are based on a Contract 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.

Date Prepared: 05/01/20

PPO

Plan 3 - 0

Prevea360 Health Plan

SCHOOL DISTRICT OF KOHLER

Product Type: PPO

Effective Date: 07/01/2020

Plan Code: PPO03449/PHA02209

Plan Overview	In Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	$2000 single / $4000 family	$4000 single / $8000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	0% coinsurance after deductible / 0% coinsurance after deductible	20% coinsurance after deductible / 20% coinsurance after deductible
Office Visit and Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Preventive Services	$0 copay	20% coinsurance after deductible
Deductible and Coinsurance Limit	$2000 single / $4000 family	N/A
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	$4000 single / $8000 family	$5250 single / $10500 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	**Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier**	
Tier 1	$20 copay	50% coinsurance
Tier 2	$45 copay	50% coinsurance
Tier 3	$70 copay	Not Covered
Tier 4	$100 copay	50% coinsurance
Tier 5	$200 copay	Not Covered
Diagnostic Services		
Diagnostic Services	0% coinsurance after deductible	20% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		
Urgent Care	0% coinsurance after deductible	0% coinsurance after in-network deductible
Emergency Room Services (Copay is waived if admitted)	$300 copay and/or 0% coinsurance after deductible	$300 copay and/or 0% coinsurance after in-network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Day Treatment Programs	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Outpatient	0% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	0% coinsurance after deductible	20% coinsurance after deductible
Plan Special Features	Plan administered on a Contract Year basis	

This renewal plan includes prescription drug coverage that is creditable
Unless otherwise noted, all benefits are based on a Contract 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.

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