Enroll Prime

Major Medical Plan Grid

	COPAY 3500		COPAY 4500		COPAY 8000		HSA 5000	MVP
SERVICE	TIER 1 PREFERRED NETWORK	TIER 2 IN-NETWORK	TIER 1 PREFERRED NETWORK	TIER 2 IN-NETWORK	TIER 1 PREFERRED NETWORK	TIER 2 IN-NETWORK	TIER 1 IN-NETWORK	TIER 1 IN-NETWORK
Deductible (Individual / Family)	$0 / $0	$3,500 / $7,000	$0 / $0	$4,500 / $9,000	$0 / $0	$8,000 / $16,000	$5,000 / $15,000	$7,000 / $14,000
Out Of Pocket Max (Individual / Family)	$7,000 / $14,000	$7,000 / $14,000	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400	$8,700 / $17,400	$5,000 / $15,000	$8,500 / $17,000
PHYSICIAN SERVICES								
Preventive Care	N/A	$0	N/A	$0	N/A	$0	$0 (Before Ded.)	$0
Primary Care Visit	N/A	$25 Copay	N/A	$40 Copay	N/A	$40 Copay	0% (After Ded.)	$40 Copay
Specialist Care Visit	$0	$45 Copay (Office)	$0	$60 Copay (Office)	$0	$80 Copay (Office)	0% (After Ded.)	$60 Copay (Office)
Physical Rehabilitation	$0	$45 Copay	$0	$60 Copay	$0	$80 Copay	0% (After Ded.)	$60 Copay (Office)
Mental Health: Outpatient	$0	$45 Copay (Office)	$0	$60 Copay (Office)	$0	$80 Copay (Office)	0% (After Ded.)	$35 Copay (Office)
Mental Health: Inpatient	$0	30% Coinsurance	$0	20% Coinsurance	$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
PREVENTIVE CARE								
Routine Adult & Child Care, Immunizations, Cancer Screenings, Mammograms, OB/GYN Visits	N/A	$0	N/A	$0	N/A	$0	$0 (Before Ded.)	$0
HOSPITAL SERVICES								
Urgent Care	$0	$65 Copay (Office)	$0	$70 Copay (Office)	$0	$100 Copay (Office)	0% (After Ded.)	$30 Copay
Diagnostic Test (X-Ray / Blood Work)	$0	$50 Copay (Individual Lab)	$0	$50 Copay (Individual Lab)	$0	$50 Copay (Individual Lab)	0% (After Ded.)	$60 Copay
Advanced Imaging (CT / MRI / PET)	$0	30% Coinsurance	$0	20% Coinsurance	$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Emergency Room	N/A	30% Coinsurance	N/A	20% Coinsurance	N/A	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Ambulance	N/A	30% Coinsurance	N/A	20% Coinsurance	N/A	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Hospital Stay	$0	30% Coinsurance	$0	20% Coinsurance	$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Outpatient Procedure	$0	30% Coinsurance	$0	20% Coinsurance	$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
Childbirth/Delivery Services	$0	30% Coinsurance	$0	20% Coinsurance	$0	30% Coinsurance	0% (After Ded.)	30% Coinsurance
PRESCRIPTION DRUGS								
Rx Deductible (Ind/Family)	N/A	N/A	N/A	$250 / $500**	N/A	$250 / $500**	N/A	$250 / $500
Rx Tier 1 Generic (30-Day / 90-Day)*	N/A	$0 / $0 Copay	N/A	$0 / $0 Copay	N/A	$0 / $0 Copay	0% (After Ded.)	$0 / $0 Copay
Rx Tier 2 Formulary Brand (30-Day / 90-Day)*	N/A	$35 / $75 Copay	N/A	$45 / $90 Copay	N/A	$55 / $110 Copay	0% (After Ded.)	$55 / $110 Copay
Rx Tier 3 Non-Formulary Brand (30-Day / 90-Day)*	N/A	$70 / $150 Copay	N/A	$90 / $180 Copay	N/A	$100 / $200 Copay	0% (After Ded.)	$100 / $200 Copay
Rx Tier 4: Specialty (30-Day / 90-Day)*	N/A	Contact EHIM	N/A	Contact EHIM	N/A	Contact EHIM	Contact EHIM	Not Covered

**Rx 30-day supply is retail only, 90-day supply is retail or mail order.*

***Deductible does not apply to generics on Copay 4500 and Copay 8000.*

Certain services require prior authorization to access benefits or avoid penalty. See your plan documents for more information.

HSA 5000 and MVP Plans are managed care plans & require prior authorization for most services.

Our team will work diligently to find you a Tier 1 provider, however there are instances where no provider is available. Tier 1 benefits are not guaranteed.