Medical Insurance

Because there is nothing more important than your health, Nexus offers five medical plans through UHP Administrators. Choice is important when selecting the right medical plan. Take the time to learn about your options to ensure you select the right plan for you and your family. All plans have a list of services that require pre-treatment authorization at least 48 hours in advance of treatment.

Please refer to the following chart for an overview. Additional details can be found in the Summary of Benefits and Coverage (SBC) or a copy of the policy for additional details.

Medical Benefits					
	Plan A	**Plan B**	**Plan C**	**Plan D (MV)**	**Plan E (MEC)**
Calendar Year Deductible (CYD)	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	$7,000 Individual/ $14,000 Family	N/A	N/A
Coinsurance (you pay after CYD)	20%	20%	40%	N/A	N/A
Out of Pocket Maximum (Includes Deductible)	$5,000 Individual/ $10,000 Family	$7,000 Individual/ $14,000 Family	$7,350 Individual/ $14,700 Family	$7,350 Individual/ $14,700 Family	$1,850 Individual/ $3,700 Family
Provider Network	Prime Health Services	Prime Health Services	Prime Health Services	Prime Health Services	Prime Health Services
Office Visit - Primary Care Physician	$20 co-pay (deductible does not apply)	$25 co-pay (deductible does not apply)	40% co-insurance after deductible	$25 co-pay (limit 10 visits per plan year, deductible does not apply)	$15 co-pay (limit 15 visits per plan year, deductible does not apply)
Office Visit - Specialist	$40 co-pay (deductible does not apply)	$50 co-pay (deductible does not apply)	40% co-insurance after deductible	$50 co-pay (limit 10 visits per plan year, deductible does not apply)	$15 co-pay (limit 15 visits per plan year, deductible does not apply)
Urgent Care Visit	$40 co-pay (deductible does not apply)	$40 co-pay (deductible does not apply)	40% co-insurance after deductible	$50 co-pay (2 visit limit per plan year, deductible does not apply)	$50 co-pay (limit 2 visits per plan year, deductible does not apply)
Emergency Room	$750 co-pay (deductible does not apply)	$750 co-pay (deductible does not apply)	40% co-insurance after deductible	$350 co-pay (1 visit limit per year, deductible does not apply)	Not Covered
Inpatient Hospitalization	20% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	$350 co-pay (limit 5 days per plan year, deductible does not apply)	Not Covered
Outpatient Surgery	20% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	$350 co-pay (limit 1 surgery per plan year, deductible does not apply)	Not Covered
Inpatient Lab Services	20% co-insurance after deductible	20% co-insurance after deductible	40% co-insurance after deductible	$350 co-pay (deductible does not apply)	Not Covered

Prescription Coverage (In-Network)	Generic: $10 co-pay Brand: $40 co-pay Non-Preferred: $85 co-pay Specialty: not covered (deductible does not apply)	Generic: $10 co-pay Brand: $40 co-pay Non-Preferred: $85 co-pay Specialty: not covered (deductible does not apply)	Generic: $15 co-pay after deductible Brand: $45 co-pay after deductible Non-Preferred: $80 co-pay after deductible Specialty: not covered	Generic: 20% co-insurance (deductible does not apply) Brand: 20% co-insurance (deductible does not apply) Non-Preferred: not covered Specialty: not covered	Generic: $15 co-pay (deductible does not apply) Brand: not covered Non-Preferred: not covered Speciality: not covered

Bi-Weekly Medical Premiums					
	Plan A	**Plan B**	**Plan C**	**Plan D (MV)**	**Plan E (MEC)**
Employee Only	$290.77	$230.77	$163.85	$117.69	$20.77
Employee + Spouse	$849.69	$738.46	$652.38	$549.23	$73.85
Employee + Children	$709.68	$664.62	$533.08	$404.31	$80.77
Family	$1,210.85	$1,051.85	$929.65	$810.12	$115.38

Corporate Semi-Monthly Medical Premiums					
	Plan A	**Plan B**	**Plan C**	**Plan D (MV)**	**Plan E (MEC)**
Employee Only	$315.00	$250.00	$177.50	$127.50	$22.50
Employee + Spouse	$920.50	$800.00	$706.75	$595.00	$80.00
Employee + Children	$768.83	$720.00	$577.50	$438.00	$87.50
Family	$1,311.75	$1,139.50	$1,007.13	$877.63	$125.00

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage(COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

