Bothwell™
Regional Health Center

2025 HEALTH INSURANCE
Premier Access Premium Plan

SUMMARY OF MEDICAL BENEFIT				
Benefit	**Bothwell**	**HCM**	**Freedom Select/Health Link/First Health**	**Out-of-Network**
Deductible – Individual/Family	$0/$0	$1,500/$3,500	$5,000/$10,000	$10,000/$20,000
Co-Insurance – Member Pays	0%	10%	30%	50%
Out-of-Pocket Maximum Individual/Family (includes deductible)	$3,500/$7,000	$3,500/$7,000	$7,000/$14,000	$15,000/$30,000
PCP/Specialist Visit	Covered at 100%	$45/$75	30% after deductible	50% after deductible
Mental Health Visit	Covered at 100%	$20 Copay	$50 Copay	50% after deductible
Preventive Care	Covered at 100%	Covered at 100%	30% after deductible	50% after deductible
Diagnostic Lab Performed in Physicians Office or Independent Lab	Covered at 100%	Covered at 10%	30% after deductible	50% after deductible
Diagnostic Lab Performed in a Hospital or Outpatient Facility	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Chiropractic/Spinal Manipulation	N/A	$60 Copay	30% after deductible	50% after deductible
Outpatient Surgery	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Walk in Clinic	Covered at 100%	$45	30% after deductible	50% after deductible
Urgent Care	N/A	$150 Copay, 10% coinsurance after deductible	30% after deductible	50% after deductible
Emergency Room Visit	$75 Copay	$150 Copay, 10% coinsurance after deductible	$300 Copay, 30% coinsurance after deductible	50% after deductible
Inpatient Hospital Services	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Inpatient or Outpatient	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Mental Health/Substance Abuse	N/A	10% after deductible	30% after deductible	50% after deductible
Bothwell Medical Equipment	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Physical and Occupational Therapy (CY Limit: 60 combined visits)	Covered at 100%	10% after deductible	30% after deductible	50% after deductible
Speech Therapy (CY Limit: 20 visits)	Covered at 100%	10% after deductible	30% after deductible	50% after deductible

SUMMARY OF PHARMACY BENEFIT		
Benefit	**Bothwell**	**Any Other Pharmacy**
Out-of-Pocket Maximum Individual/Family	**$3,500/$7,000**	
30 Day		
Tier 1 Generic Drugs	$5 Copay	Greater of $35 copay or 20%
Tier 2 Preferred Name Brand Drugs	$20 Copay	Greater of $70 copay or 50%
Tier 3 Non-Preferred Name Brand Drugs	$40 Copay	Greater of $125 copay or 60%
Specialty Tier	20%	40%
90 Day		
Tier 1 Generic Drugs	$10 Copay	Greater of $70 copay or 20%
Tier 2 Preferred Name Brand Drugs	$40 Copay	Greater of $140 copay or 50%
Tier 3 Non-Preferred Name Brand Drugs	$80 Copay	Greater of $250 copay or 60%
Specialty Tier	Not Covered	Not Covered

**DME and Imaging – No Prior Auth.* **90-day maintenance medications required to be filled at Employee Pharmacy*

Rev. 11.6.2024