

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-356-2219 or visit [www.phs.org](http://www.phs.org). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-356-2219 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$3,200/Individual / \$6,400/Family  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and any benefit where there is no charge (except for HDHPs) are covered before you meet your <a href="#">deductible</a> .                                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$5500 Individual / \$11000 Family   | The <a href="#">out of pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out of pocket limit</a> until the overall family <a href="#">out of pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out of pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <b>Group HMO/POS at <a href="https://www.phs.org/directory?network=IFGHP">https://www.phs.org/directory?network=IFGHP</a> or call 1-800-356-2219</b> for a list of participating providers. | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out of network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out of network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the <a href="#">specialist</a> you choose without a referral.   |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event   | Services You May Need                                   | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|---|---|--|---|
|  |   | In-network Provider<br>(You will pay the least)                                     | Out-of-network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | \$30 <a href="#">copayment</a> /visit<br><a href="#">deductible</a> does not apply  | Not covered  | All other services <a href="#">deductible</a> or <a href="#">coinsurance</a> may apply. There is zero cost sharing for any telehealth service.                            |
|  | <a href="#">Specialist</a> visit                        | \$90 <a href="#">copayment</a> /visit<br><a href="#">deductible</a> does not apply  | Not covered  | All other services <a href="#">deductible</a> or <a href="#">coinsurance</a> may apply. There is zero cost sharing for any telehealth service.                            |
|  | <a href="#">Preventive care/screening</a> /immunization | No charge <a href="#">deductible</a> does not apply                                 | Not covered  | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)     | No charge <a href="#">deductible</a> does not apply.                                | Not covered  | Prior authorization is required or benefits may be denied.  |
|  | Imaging (CT/PET scans, MRIs)                            | \$300 <a href="#">copayment</a> /test<br><a href="#">deductible</a> does not apply. | Not covered  |   |

| Common Medical Event  | Services You May Need                          | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | In-network Provider<br>(You will pay the least)   | Out-of-network Provider<br>(You will pay the most)  |  |
| <p><b>If you need drugs to treat your illness or condition</b><br/>           More information about <a href="#">prescription drug coverage</a> is available at <a href="https://phs.org/formsanddocuments">phs.org/formsanddocuments</a></p> | Preferred Generic Drugs (Tier 1)               | No charge (retail) per 30-day supply<br><a href="#">deductible</a> does not apply / No charge (mail order) <a href="#">deductible</a> does not apply  | No charge (retail) per 30-day supply<br><a href="#">deductible</a> does not apply / No charge (mail order) <a href="#">deductible</a> does not apply  | <p>Max 90-day supply at retail. Tier 4 Self-Administered specialty limited to 30-day supply and Not covered at Mail. Preferred insulin or medically necessary alternative will not exceed \$25 copayment per 30-day supply, after deductible has been met. Prior authorization may be required. Pharmacy Transactions where Manufacturer discount or Copay assistance cards are used will not count towards Deductible or Out of Pocket. Refer to the formulary for a complete listing and coverage details.</p> <p>Prior authorization may be required.</p> |
|   | Non-Preferred Generic Drugs (Tier 2)           | \$15 <a href="#">copayment</a> (retail) per 30-day supply<br><a href="#">deductible</a> does not apply / \$45 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply  | \$15 <a href="#">copayment</a> (retail) per 30-day supply<br><a href="#">deductible</a> does not apply / \$45 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply  |  |
|   | Preferred Brand Drugs (Tier 3)                 | \$60 <a href="#">copayment</a> (retail) per 30-day supply<br><a href="#">deductible</a> does not apply / \$180 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply | \$60 <a href="#">copayment</a> (retail) per 30-day supply<br><a href="#">deductible</a> does not apply / \$180 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply |  |
|   | Non-preferred drugs (Tier 4)                   | \$150 <a href="#">copayment</a> (retail) 30-day supply<br><a href="#">deductible</a> does not apply / \$450 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply    | \$150 <a href="#">copayment</a> (retail) 30-day supply<br><a href="#">deductible</a> does not apply / \$450 <a href="#">copayment</a> (mail order) <a href="#">deductible</a> does not apply    |  |
|   | Self-Administered Specialty (Tier 5)           | 20% <a href="#">coinsurance</a> (retail) after <a href="#">deductible</a> is met - Limited to 30-day supply maximum / Not covered (mail order)  | Not Covered   |  |
| <p><b>If you have outpatient surgery</b></p>  | Facility fee (e.g., ambulatory surgery center) | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met   | Not covered   | Prior authorization is required or benefits may be denied.   |
|   | Physician/surgeon fees                         | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met   | Not covered   | Prior authorization is required or benefits may be denied.   |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | In-network Provider (You will pay the least)  | Out-of-network Provider (You will pay the most)   |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$500 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply  | \$500 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply  | No charge for anything related to COVID-19 screening, testing, or medical treatment. Balance billing is not allowed for out-of-network care. |
|   | <a href="#">Emergency medical transportation</a> | \$250 <a href="#">copayment</a> /ground. 20% <a href="#">coinsurance</a> /Air Ambulance after <a href="#">deductible</a> is met | \$250 <a href="#">copayment</a> /ground. 20% <a href="#">coinsurance</a> /Air Ambulance after <a href="#">deductible</a> is met | No charge for anything related to COVID-19 screening, testing, or medical treatment. Balance billing is not allowed for out-of-network care. |
|   | <a href="#">Urgent care</a>                      | \$30 <a href="#">copayment</a> /visit. <a href="#">deductible</a> does not apply  | \$30 <a href="#">copayment</a> /visit. <a href="#">deductible</a> does not apply  | No charge for anything related to COVID-19 screening, testing, or medical treatment. Balance billing is not allowed for out-of-network care. |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met   | Not covered   | Prior authorization is required or benefits may be denied.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met   | Not covered   | Prior authorization is required or benefits may be denied.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge <a href="#">deductible</a> does not apply   | Not covered   | -----None-----   |
|   | Inpatient services                               | No charge <a href="#">deductible</a> does not apply   | Not covered   | Prior authorization is required or benefits may be denied.   |
| If you are pregnant   | Office visits                                    | \$300 <a href="#">copayment</a> per pregnancy <a href="#">deductible</a> does not apply   | Not covered   | Cost sharing does not apply for preventative services. Prior authorization is not required for maternity ultrasounds.                        |
|   | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met   | Not covered   | Prior authorization is not required for maternity ultrasounds.   |
|   | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met   | Not covered   | Prior authorization is not required for maternity ultrasounds.   |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|--|---|---|---|---|
|  |   | In-network Provider<br>(You will pay the least)                                 | Out-of-network Provider<br>(You will pay the most)                          |   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met         | Not Covered   | Coverage is limited to 100 days/plan year. Prior authorization is required or benefits may be denied.   |
|  | <a href="#">Rehabilitation services</a>   | \$30 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply | Not Covered   | Prior authorization is required or benefits may be denied.  |
|  | <a href="#">Habilitation services</a>     | \$30 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply | Not Covered   |   |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met         | Not Covered   | Coverage is limited to 60 days/plan year. Prior authorization is required or benefits may be denied.  |
|  | <a href="#">Durable medical equipment</a> | 45% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met         | Not Covered   | Prior authorization is required or benefits may be denied.  |
|  | <a href="#">Hospice services</a>          | \$200 <a href="#">copayment</a> /day <a href="#">deductible</a> does not apply  | Not Covered   | Prior authorization is required or benefits may be denied.  |
| If your child needs dental or eye care                         | Children's eye exam                       | No Charge <a href="#">deductible</a> does not apply                             | \$55.00 <a href="#">copayment</a> <a href="#">deductible</a> does not apply | One eye refraction exam associated with post cataract surgery or keratoconus correction per year is covered; additional charges may apply.                              |
|  | Children's glasses                        | No charge <a href="#">deductible</a> does not apply                             | \$40.00 <a href="#">copayment</a> <a href="#">deductible</a> does not apply | Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus is limited to once a year; additional charges may apply. |
|  | Children's dental check-up                | Not covered   | Not covered   | -----None-----  |

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check up (Child) - Coverage is available in the Insurance market and can be purchased as a stand-alone product.
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care \* Only covered when medically necessary for diabetes. See GSA for details.

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion Services (excepted and non-excepted)
- Acupuncture (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Bariatric Surgery
- Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Hearing Aids
- Infertility Treatment
- Routine Eye Care (Adult) limited to one eye exam per year only
- Weight Loss Programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [appeal](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standard](#), you may be eligible for a [premium tax credits](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Para obtener asistencia en Español, llame al 1-800-356-2219.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-356-2219.

如果需要中文的帮助, 请拨打这个号码 1-800-356-2219.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-356-2219.

Learn more about Presbyterian's Notice of Nondiscrimination, go to [www.phs.org/nondiscrimination.aspx](http://www.phs.org/nondiscrimination.aspx).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)  |                    | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)   |                   | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)  |                   |
|--|--------------------|--|-------------------|--|-------------------|
| ■ The plan's overall deductible  | \$3,200            | ■ The plan's overall deductible  | \$3,200           | ■ The plan's overall deductible  | \$3,200           |
| ■ Specialist   | \$90               | ■ Specialist   | \$90              | ■ Specialist   | \$90              |
| ■ Hospital (Facility)  | 20%                | ■ Hospital (Facility)  | 20%               | ■ Hospital (Facility)  | 20%               |
| ■ Other  | 20%                | ■ Other  | 20%               | ■ Other  | 20%               |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |                    | <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |                   | <b>This EXAMPLE event includes services like:</b><br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |                   |
| <b>Total Example Cost</b>  | <b>\$12,700.00</b> | <b>Total Example Cost</b>  | <b>\$5,600.00</b> | <b>Total Example Cost</b>  | <b>\$2,800.00</b> |
| <b>In this example, Peg would pay:</b>   |                    | <b>In this example, Joe would pay:</b>   |                   | <b>In this example, Mia would pay:</b>   |                   |
| <i>Cost Sharing</i>  |                    | <i>Cost Sharing</i>  |                   | <i>Cost Sharing</i>  |                   |
| Deductibles  | \$3,200.00         | Deductibles  | \$800.00          | Deductibles  | \$300.00          |
| Copayments   | \$300.00           | Copayments   | \$900.00          | Copayments   | \$1,200.00        |
| Coinsurance  | \$1,100            | Coinsurance  | \$0.00            | Coinsurance  | \$0.00            |
| <i>What isn't covered</i>  |                    | <i>What isn't covered</i>  |                   | <i>What isn't covered</i>  |                   |
| Limits or exclusions   | \$60.00            | Limits or exclusions   | \$20.00           | Limits or exclusions   | \$0.00            |
| <b>The total Peg would pay is</b>  | <b>\$4,660.00</b>  | <b>The total Joe would pay is</b>  | <b>\$1,720.00</b> | <b>The total Mia would pay is</b>  | <b>\$1,500.00</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.