PRESBYTERIAN 2022 Group LF HMO Silver 7 Engage

Coverage for: Individual or Family | **Plan Type:** HMO

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. 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 deductible?	$0/Individual / $0/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and any benefit where there is no charge (except for HDHPs) are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,700 Individual / $17,400 Family	The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out of pocket limit until the overall family out of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See **Engage Network @ https://www.phs.org/directory?network=ENGAGE or call 1-800-356-2219** for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist 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 (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copayment/visit deductible does not apply	Not covered	All other services deductible or coinsurance may apply. There is zero cost sharing for any telehealth service.
	Specialist visit	$90 copayment/visit deductible does not apply	Not covered	All other services deductible or coinsurance may apply. There is zero cost sharing for any telehealth service.
	Preventive care/screening/immunization	No charge deductible 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 plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$100 copayment x-ray $50 copayment /visit for blood work deductible does not apply	Not covered	Prior authorization is required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	30% deductible does not apply	Not covered	

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 drugs to treat your illness or condition More information about prescription drug coverage is available at phs.org/formsanddocuments	Preferred Generic Drugs (Tier 1)	No charge (retail) per 30-day supply deductible does not apply / No charge (mail order) deductible does not apply	No charge (retail) per 30-day supply deductible does not apply / No charge (mail order) deductible does not apply	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. Prior Authorization may be required.
	Non-Preferred Generic Drugs (Tier 2)	$15 copayment (retail) per 30-day supply deductible does not apply / $45 copayment (mail order) deductible does not apply	$15 copayment (retail) per 30-day supply deductible does not apply / $45 copayment (mail order) deductible does not apply	
	Preferred Brand Drugs (Tier 3)	$75 copayment (retail) per 30-day supply deductible does not apply / $225 copayment (mail order) deductible does not apply	$75 copayment (retail) per 30-day supply deductible does not apply / $225 copayment (mail order) deductible does not apply	
	Non-preferred drugs (Tier 4)	$150 copayment (retail) per 30-day supply deductible does not apply / $450 copayment (mail order) deductible does not apply	$150 copayment (retail) per 30-day supply deductible does not apply / $450 copayment (mail order) deductible does not apply	
	Self-Administered Specialty (Tier 5)	30% coinsurance (retail) after deductible is met - Limited to 30-day supply maximum / Not covered (mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1000 copayment deductible does not apply	Not covered	Prior authorization is required or benefits may be denied.
	Physician/surgeon fees	$1000 copayment deductible does not apply	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	Emergency room care	$1000 copayment deductible does not apply	$1000 copayment deductible 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.
	Emergency medical transportation	30% coinsurance after deductible is met; No charge inter-facility deductible does not apply	30% coinsurance after deductible is met; No charge inter-facility deductible 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.
	Urgent care	$35 copayment deductible does not apply	$35 copayment deductible 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)	$1200 copayment/day up to $2400 max deductible does not apply	Not covered	Prior authorization is required or benefits may be denied.
	Physician/surgeon fees	No Charge deductible does not apply	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 deductible does not apply	Not covered	----------None----------
	Inpatient services	No charge deductible does not apply	Not covered	Prior authorization is required or benefits may be denied.
If you are pregnant	Office visits	$300 copayment per pregnancy deductible 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	No charge deductible does not apply	Not covered	Prior Authorization is not required for maternity ultrasounds.
	Childbirth/delivery facility services	$1200 copayment/day up to $2400 max deductible does not apply	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 (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible has been met	Not covered	Coverage is limited to 100 days/plan year. Prior authorization is required or benefits may be denied.
	Rehabilitation services	$35 copayment deductible does not apply	Not covered	Prior authorization is required or benefits may be denied.
	Habilitation services	$35 copayment deductible does not apply	Not covered	
	Skilled nursing care	$1200 copayment/day up to $2400 max deductible does not apply	Not covered	Coverage is limited to 60 days/calendar year. Prior authorization is required or benefits may be denied.
	Durable medical equipment	50% coinsurance after deductible has been met	Not covered	Prior authorization is required or benefits may be denied.
	Hospice services	$1200 copayment/day up to $2400 max deductible 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 deductible does not apply	$55.00 copayment deductible 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 deductible does not apply	$40.00 copayment deductible 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. 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 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, kwiijigo holne' 1-800-356-2219.
Learn more about Presbyterian's Notice of Nondiscrimination, go to 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
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist	$90
Hospital (Facility)	1200%
Other	1200%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700.00**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$3,400.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	$3,460.00

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist	$90
Hospital (Facility)	1200%
Other	1200%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600.00**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1,000.00
Coinsurance	$200.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	$1,220.00

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist	$90
Hospital (Facility)	1200%
Other	1200%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800.00**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1,300.00
Coinsurance	$100.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$1,400.00

The **plan** would be responsible for the other costs of these EXAMPLE covered services.