PRESBYTERIAN

Silver Select 7000 w/ GYM - with EXTRA SAVINGS 73% - Limited Service Area

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

The Summary of Benefits and Coverage (SBC) document will helpyouchoose a health plan. The SBC shows you how you and the planwould 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 1-855-923-7528 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 1-855-923-7528 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,350**/Individual / **$6,700**/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, Behavioral Health services, any benefit where there is no charge (except for HDHPs), Covid-19 screening, testing, treatment, vaccines, boosters and any service that has a copayment.	This plan covers some items & services even if you haven't 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?	**$7,550** Individual / **$15,100** 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 youuse a network provider?	Yes. See Individual Select HMO Network at https://www2.phs.org/providers/?insurance_plans=individual-select-hmo or call 1-800-923-6980 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	$40 copayment/visit deductible does not apply	Not covered	There is zero cost sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge. No charge for anything related to COVID-19 screening, testing, vaccines, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds.
	Specialist visit	$80 copayment/visit deductible does not apply	Not covered	There is zero cost sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge. No charge for anything related to COVID-19 screening, testing, vaccines, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds.
	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. There is zero cost sharing for any telehealth service. No charge for anything related to COVID-19 screening, testing, vaccines, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds.
If you have a test	Diagnostic test (x-ray, blood work)	$110 copayment/test x-ray $50 copayment/visit blood work deductible does not apply	Not covered	Prior authorization may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible is met	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** https://client.formularynavigator.com/Search.aspx?siteCode=0324498195	Preferred Generic Drugs (Tier 1)	$20 copayment (retail) per 30-day supply deductible does not apply / $60 copayment (mail order) deductible does not apply	$20 copayment (retail) per 30-day supply deductible does not apply / $60 copayment (mail order) deductible does not apply	Max 90-day supply at retail. Tier 5 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. Pharmacy Transactions where Manufacturer discount or Copay assistance cards are used will count towards Deductible or Out of Pocket. Refer to the formulary for a complete listing and coverage details. Prior authorization may be required or benefits may be denied.
	Non-Preferred Generic Drugs (Tier 2)	$20 copayment (retail) per 30-day supply deductible does not apply / $60 copayment (mail order) deductible does not apply	$20 copayment (retail) per 30-day supply deductible does not apply / $60 copayment (mail order) deductible does not apply	
	Preferred Brand Drugs (Tier 3)	$120 copayment (retail) per 30-day supply deductible does not apply / $360 copayment (mail order) deductible does not apply	$120 copayment (retail) per 30-day supply deductible does not apply / $360 copayment (mail order) deductible does not apply	
	Non-preferred drugs (Tier 4)	10% coinsurance (retail) per 30-day supply after deductible is met	10% coinsurance (retail) per 30-day supply after deductible is met	
	Self-Administered Specialty (Tier 5)	10% 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)	10% coinsurance after deductible is met	Not covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	10% coinsurance after deductible is met	Not covered	Prior Authorization may be 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	$750 copayment/visit deductible does not apply	$750 copayment/visit deductible does not apply	No charge for anything related to COVID-19 screening, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. There is zero cost sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge.
	Emergency medical transportation	10% coinsurance /ground or air after deductible is met	10% coinsurance /ground or air after deductible is met	No charge for anything related to COVID-19 screening, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care.
	Urgent care	$40 copayment/visit deductible does not apply	$40 copayment/visit deductible does not apply	No charge for anything related to COVID-19 screening, testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. There is zero cost sharing for any telehealth service. Copayment does not include Medical Drugs which will have a separate charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible is met	Not covered	Prior Authorization may be required or benefits may be denied.
	Physician/surgeon fees	10% coinsurance after deductible is met	Not covered	Prior Authorization may be 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	There is no cost-sharing for behavioral health services or drugs. Acute Medical Detoxification Benefits are Covered for no less than 30 outpatient visits for alcohol dependency treatment.
	Inpatient services	No charge deductible does not apply	Not covered	There is no cost-sharing for behavioral health services or drugs. Acute Medical Detoxification Benefits are Covered and will cover no less than 30 days in an alcohol dependency treatment center

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 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 gynecological or obstetrical ultrasounds.
	Childbirth/delivery professional services	10% coinsurance after deductible has been met	Not covered	Prior authorization may be required or benefits may be denied. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	10% coinsurance after deductible has been met	Not covered	Prior authorization may be required or benefits may be denied. Cost sharing does not apply for preventative services. Prior Authorization is not required for gynecological or obstetrical ultrasounds.
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible is met	Not covered	Prior authorization may be required or benefits may be denied.
	Rehabilitation services	$40 copayment deductible does not apply	Not covered	Prior authorization may be required or benefits may be denied.
	Habilitation services	$40 copayment deductible does not apply	Not covered	
	Skilled nursing care	10% coinsurance after deductible is met	Not covered	Prior authorization may be required or benefits may be denied.
	Durable medical equipment	10% coinsurance after deductible is met	Not covered	Prior authorization may be required or benefits may be denied.
	Hospice services	10% coinsurance after deductible is met	Not covered	Prior authorization may be required or benefits may be denied.
If your child needs dental oreye care	Children's eye exam	No charge deductible does not apply	$55 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 copayment deductible does not apply	Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus or hen related to Genetic Inborn Errors of Metabolism, 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	• Long-Term Care	• Private-Duty Nursing
• Dental Care (Adult)	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care * Only covered whenmedically 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)	• Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc)	• Routine Eye Care (Adult) limited to one eye exam per year only
• Acupuncture (20 visits per calendar yearunless for rehabilitative or habilitative svc)	• Hearing Aids	• Weight Loss Programs
• Bariatric Surgery	• Infertility Treatment	

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	**$3,350**
Specialist	**80%**
Hospital (Facility)	**10%**
Other	**10%**

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	$3,350.00
Copayments	$1,100.00
Coinsurance	$500.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	$5,010.00

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

The plan's overall deductible	**$3,350**
Specialist	**80%**
Hospital (Facility)	**10%**
Other	**10%**

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	$800.00
Copayments	$1,100.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	$1,920.00

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

The plan's overall deductible	**$3,350**
Specialist	**80%**
Hospital (Facility)	**10%**
Other	**10%**

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	$1,200.00
Copayments	$900.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$2,100.00

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