PRESBYTERIAN Customized Smart Care $4000_$30

**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?** | **$4,000** Individual / **$8,000** 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, Covid-19 testing, treatment, vaccines, boosters and any service that has a copayment | This plan covers some items & 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?** | **$6,350** Individual / **$12,700** 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 Group HMO Network at https://www2.phs.org/providers/?insurance_plans=individual-and-family-or-group-hmopos 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 | $30 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 testing, vaccines, or medical treatment. Prior authorization is not required for gynecological or obstetrical ultrasounds. |
| | Specialist visit | $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 copayment. No charge for anything related to COVID-19 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. No charge for anything related to COVID-19 testing, vaccines, or medical treatment. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge deductible does not apply | Not covered | Prior authorization may be required or benefits may be denied. |
| | Imaging (CT/PET scans, MRIs) | $200 copayment/test 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 https://client.formularynavigator.com/Search.aspx?siteCode=0322075909** | Generic drugs (Tier 1) | $10 copayment (retail 30-day supply) / $20 copayment (mail order) deductible does not apply | $10 copayment (retail 30-day supply) / $20 copayment (mail order) deductible does not apply | Max 90-day supply at retail - Mail Order benefits administered by OptumRx Home Delivery. Tier 4 Self-Administered specialty limited to 30-day supply and Not covered at Mail.<br><br>Preferred insulin or medically necessary alternative will not exceed $25 copayment per 30-day supply.<br><br>Prior authorization may be required or benefits may be denied.<br><br>Pharmacy Transactions where Manufacturer discount or Copay assistance cards are used will count towards Deductible or Out of Pocket.<br><br>Refer to the formulary for a complete listing and coverage details. |
| | Preferred brand drugs (Tier 2) | $35 copayment (retail 30-day supply) / $87.50 copayment (mail order) deductible does not apply | $35 copayment (retail 30-day supply) / $87.50 copayment (mail order) deductible does not apply | |
| | Non-preferred drugs (Tier 3) | $55 copayment (retail 30-day supply) / $165 copayment (mail order) deductible does not apply | $55 copayment (retail 30-day supply) / $165 copayment (mail order) deductible does not apply | |
| | Self-Administered Specialty (Tier 4) | 20% coinsurance up to a maximum of $400 per prescription (retail) Limited to 30-day supply maximum deductible does not apply/ Not covered (mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | 30% 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 | $300 copayment/visit deductible does not apply | $300 copayment/visit deductible does not apply | Copayment is waived if admitted into a Hospital. Medical drugs will apply a separate copay. No charge for anything related to COVID-19 testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. |
| | Emergency medical transportation | $50 copayment/occurrence ground; $100 copayment/occurrence air; No charge inter-facility deductible does not apply | $50 copayment/occurrence ground; $100 copayment/occurrence air; No charge inter-facility deductible does not apply | No charge for anything related to COVID-19 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 | Medical drugs will apply a separate copay. No charge for anything related to COVID-19 testing, medical treatment, vaccines/boosters. Balance billing is not allowed for out-of-network care. There is zero cost sharing for any telehealth service. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. |
| | Physician/surgeon fees | 30% 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 in-network cost sharing for Behavioral Health Service or Drugs, unless otherwise authorized by your plan. 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 in-network cost sharing for Behavioral Health Service or Drugs, unless otherwise authorized by your plan. 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 | $30 copayment/visit up to $300copayment/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 | 30% coinsurance after deductible is met | Not covered | Prior Authorization is not required for gynecological or obstetrical ultrasounds. |
| | Childbirth/delivery facility services | 30% coinsurance after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. Prior Authorization is not required for gynecological or obstetrical ultrasounds. |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. |
| | Rehabilitation services | $30 copayment deductible does not apply | Not covered | Prior authorization may be required or benefits may be denied. |
| | Habilitation services | $30 copayment/visit deductible does not apply | Not covered | Prior authorization may be required or benefits may be denied. |
| | Skilled nursing care | 30% coinsurance after deductible is met | Not covered | Coverage is limited up to 60 days/plan year. Prior authorization may be required or benefits may be denied. |
| | Durable medical equipment | 30% coinsurance after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. |
| | Hospice services | 30% coinsurance after deductible is met | Not covered | Prior authorization may be required or benefits may be denied. |
| **If your child needs dental or eye care** | Children's eye exam | Included in office visit copayment deductible does not apply | Not covered | Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction. |
| | Children's glasses | 50% coinsurance after deductible is met | Not covered | Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery, correction of Keratoconus or when related to Genetic Inborn Errors of Metabolism. Prior authorization may be required or benefits may be denied. |
| | 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)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- 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.)**

- Acupuncture (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Bariatric Surgery (for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related comorbid medical conditions)
- Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Hearing Aids (1 per ear, every 3 years)
- Infertility Treatment (Diagnosis and medically indicated treatments for physical conditions causing infertility)
- Weight Loss Programs (Includes coverage for drugs and programs if medically necessary for morbid obesity and obesity)

**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** | **$4,000** |
| **Specialist** | **$40** |
| **Hospital (Facility)** | **30%** |
| **Other** | **30%** |

**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** | **$12,738** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $100 |
| Coinsurance | $2,737 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $4,897 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$4,000** |
| **Specialist** | **$40** |
| **Hospital (Facility)** | **30%** |
| **Other** | **30%** |

**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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $890 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | $945 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$4,000** |
| **Specialist** | **$40** |
| **Hospital (Facility)** | **30%** |
| **Other** | **30%** |

**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** | **$1,925** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $190 |
| Copayments | $270 |
| Coinsurance | $92 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $553 |

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