

2024 Small Group Engage Overview

Engage Benefits	Platinum Engage w/Gym - Limited Network	Gold Engage \$1,500 w/Gym - Limited Network	Gold Engage \$3,500 w/Gym - Limited Network	Silver Engage \$4,000 w/Gym - Limited Network	Silver Engage \$7,000 w/ Gym - Limited Network	Silver Engage \$0 w/Gym - Limited Network	Silver Engage TytoHome w/Gym - Limited Network
A <b>deductible</b> is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	\$500	\$1,500	\$3,500	\$4,000	\$7,000	\$0	\$4,000
What do I pay for covered benefits?	Copayment – Benefits with a copayment (\$) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and/or coinsurance. Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.						
Preventive Care	You pay \$0. Plan pays 100% for clinical preventive health services such as physical exam, colonoscopy and routine immunizations.						
Primary Care Provider Visit	\$10	\$40	\$40	\$40	\$40	\$35	\$50, \$0 TytoHome
Urgent Care	\$10	\$40	\$40	\$40	\$40	\$35	\$50, \$0 TytoHome
Telehealth/Video Visit	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist Visit	\$30	\$90	\$90	\$90	\$90	\$90	\$100, \$0 TytoHome
Mental Health Outpatient Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Lab	\$0	\$0	\$0	\$50	\$50	\$50	\$50
X-Ray	\$0	\$0	\$0	\$100	\$100	\$100	\$100
Imaging CT/PET/MRI	\$250	\$500	\$500	\$750	\$500	30%	\$500
Emergency Room Plans with copay (\$) all services are included	\$250	\$500	\$500	\$750	30%	\$1,000	\$1,000
Ambulance Ground or Air	20% air, \$250 ground	20% air, \$250 ground	20% air, \$250 ground	30% air, \$250 ground	30% air, \$250 ground	30% air, \$250 ground	20% air, \$250 ground
Hospital Inpatient or Outpatient	20%	20%	20%	30%	30%	Inpatient: \$1,200 per day, 2 day max Outpatient: \$1,000	20%
Chiropractic and Acupuncture Limited to 20 visits each	\$10	\$40	\$40	\$40	\$40	\$35	\$50
Rehabilitation Therapy Physical, Occupational and Speech	\$10	\$40	\$40	\$40	\$40	\$35	\$50
Prescription Drugs per 30-day supply							
Tier 1: Preferred Generic	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Tier 2: Non-Preferred Generic	\$10	\$20	\$15	\$25	\$15	\$25	\$25
Tier 3: Preferred Brand	\$20	\$50	\$50	\$130	\$125	\$150	\$130
Tier 4: Non-Preferred Brand	\$75	\$125	\$125	\$150	30%	\$200	\$150
Tier 5: Specialty Pharmaceuticals	20%	20%	20%	30%	30%	30%	20%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance and prescription drug costs that you pay							
The family out-of-pocket maximum is 2x the individual out-of-pocket maximum.	\$3,200	\$9,450	\$9,450	\$9,450	\$9,450	\$9,450	\$9,450
Wellness and Other Services							
Fitness Center Membership	You and your enrolled dependents (ages 18 and up) will have free access to more than 10,000 participating fitness centers.						
Vision	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)						
Dental	We have partnered with DentalSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (Underwritten and administered by Companion Life Insurance Company.)						
The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-356-2219 or refer to the Subscriber Agreement and/or Summary of Benefits Coverage, which can be found online at <a href="http://www.phs.org/formsanddocuments">www.phs.org/formsanddocuments</a> .							