



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 1-855-923-7521 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 1-855-923-7521 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,500</b> Individual / <b>\$3,000</b> 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> , Behavioral Health services, any benefit where there is no charge, Covid-19 testing, treatment and vaccines, and any service that has a <a href="#">copayment</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> ?	<b>\$9,200</b> Individual / <b>\$18,400</b> 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 Docs. Engage Network <a href="https://www2.phs.org/providers?insurance_plans=engage">https://www2.phs.org/providers?insurance_plans=engage</a> or call <b>1-855-923-7521</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="#">provider network</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 (You will pay the least)	Out-of-network Provider (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	\$40 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	There is zero cost-sharing for any telehealth service. <a href="#">Copayment</a> does not include Medical Drugs which will have a separate charge. No cost sharing for COVID testing, treatment and vaccines. Prior authorization is not required for gynecological or obstetrical ultrasounds.
	<a href="#">Specialist</a> visit	\$90 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	
	<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 <a href="#">preventive</a> . Ask your provider if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. There is zero cost-sharing for any telehealth service. <a href="#">Copayment</a> does not include Medical Drugs which will have a separate charge. No cost sharing for COVID testing, treatment and vaccines. Prior authorization is not required for gynecological or obstetrical ultrasounds.
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 may be required or benefits may be denied.
	Imaging (CT/PET scans, MRIs)	\$500 <a href="#">copayment</a> /test <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 (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://client.formularynavigator.com/Search.aspx?siteCode=0324498195">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=0324498195">https://client.formularynavigator.com/Search.aspx?siteCode=0324498195</a>	Preferred Generic Drugs (Tier 1)	No charge (retail) per 30-day supply, No charge (mail order); <a href="#">deductible</a> does not apply	Not covered	Max 90-day supply at retail - Mail Order benefits administered by OptumRx Home Delivery. Tier 5 Self- Administered specialty limited to 30-day supply and Not covered at Mail.
	Non-Preferred Generic Drugs (Tier 2)	\$5 <a href="#">copayment</a> (retail) per 30-day supply, \$15 <a href="#">copayment</a> (mail order); <a href="#">deductible</a> does not apply	Not covered	Preferred insulin or medically necessary alternative will not exceed \$25 copayment per 30-day supply. Prior authorization may be required or benefits may be denied.
	Preferred Brand Drugs (Tier 3)	\$15 <a href="#">copayment</a> (retail) per 30-day supply, \$45 <a href="#">copayment</a> (mail order); <a href="#">deductible</a> does not apply	Not covered	Out-of-Network prescription drugs are covered in urgent situations. The In-Network cost share applies.
	Non-preferred Drugs (Tier 4)	\$100 <a href="#">copayment</a> (retail) per 30-day supply, \$300 <a href="#">copayment</a> (mail order); <a href="#">deductible</a> does not apply	Not covered	Pharmacy Transactions where Manufacturer discount or Copay assistance cards are used will not count towards Deductible or Out of Pocket.
	Self-Administered Specialty Drugs (Tier 5)	50% <a href="#">coinsurance</a> (retail), Not available (mail order)	Not covered	Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance use disorders will be covered at No Charge to you, when obtained from a participating pharmacy. See your plan's covered drug list for details  Refer to the formulary for a complete listing and coverage details.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider. Prior authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	
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 cost sharing for COVID testing, treatment and vaccines. <a href="#">Balance billing</a> is not allowed for out-of-network care.
	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">copayment</a> Ground and Air <a href="#">deductible</a> does not apply	\$250 <a href="#">copayment</a> Ground and Air <a href="#">deductible</a> does not apply	No cost sharing for COVID testing, treatment and vaccines. <a href="#">Balance billing</a> is not allowed for out-of-network care.
	<a href="#">Urgent care</a>	\$40 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	\$40 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	No cost sharing for COVID testing, treatment and vaccines. <a href="#">Balance billing</a> is not allowed for out-of-network care. There is zero cost sharing for any telehealth services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider. Prior authorization may be required or benefits may be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No charge <a href="#">deductible</a> does not apply	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider. There is no in-network cost-sharing for Behavioral Health Services or Drugs. Acute Medical Detoxification Benefits are Covered and will cover no less than 30 days Inpatient in an Alcohol Dependency Treatment Center and no less than 30 Outpatient visits for Alcohol Dependency Treatment.
	Inpatient services	No charge <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 (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you are pregnant	Office visits	\$300 <a href="#">copayment</a> /pregnancy <a href="#">deductible</a> does not apply	Not covered	Cost sharing does not apply for <a href="#">preventive</a> services. Prior authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider. Prior authorization may be required or benefits may be denied. Cost sharing does not apply for <a href="#">preventive</a> services. Prior authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 100 days/calendar. Prior authorization may be required or benefits may be denied.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	There are no limits on services for habilitative or rehabilitative services. Prior authorization may be required or benefits may be denied.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider. There are no limits on services for habilitative or rehabilitative services. Please check with your provider. Prior authorization may be required or benefits may be denied.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited up to 60 days/calendar year. Prior authorization may be required or benefits may be denied.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	Prior authorization may be 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 may be 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> /visit <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> /visit <a href="#">deductible</a> does not apply	Eyeglasses and contact lenses within 12 months following cataract surgery, correction of keratoconus or when related to Genetic Inborn Errors of Metabolism is limited to once a year; additional charges may apply. 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                                                                                                       | • Long-Term Care                                     | • Private-Duty Nursing                                                                         |
| • Dental Care (Adult)                                                                                                    | • Non-Emergency Care When Traveling Outside the U.S. | • Routine Foot Care * only covered when medically necessary for diabetes. See SPD for details. |
| • Dental check-up (Child) – Coverage is available in the Insurance Market and can be purchased as a stand-alone product. |                                                      |                                                                                                |

**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 Rehabilitation or Habilitative Services)               | • Routine Eye Care (Adult) limited to one eye exam per year (available with the purchase of the vision rider)           |
| • Acupuncture (20 visits per Calendar Year unless for Rehabilitation or Habilitative Services)                                                                                                  | • Hearing Aids (one ear, every three years)                                                                        | • Weight Loss Programs (Includes coverage for drugs and programs if medically necessary for morbid obesity and obesity) |
| • 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) | • Infertility Treatment (Diagnosis and medically indicated treatments for physical conditions causing infertility) |                                                                                                                         |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <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 [claim](#). 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 1-855-923-7521.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-923-7521.

如果需要中文的帮助, 请拨打这个号码 1-855-923-7521.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-923-7521.

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 (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plans</a> overall <a href="#">deductible</a>	\$1,500	■ The <a href="#">plans</a> overall <a href="#">deductible</a>	\$1,500	■ The <a href="#">plans</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist</a>	\$90	■ <a href="#">Specialist</a>	\$90	■ <a href="#">Specialist</a>	\$90
■ Hospital (Facility)	20%	■ Hospital (Facility)	20%	■ Hospital (Facility)	20%
■ Other	20%	■ Other	20%	■ Other	20%
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$1,500	Deductibles	\$800	Deductibles	\$300
Copayments	\$300	Copayments	\$900	Copayments	\$1,200
Coinsurance	\$1,400	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,260</b>	<b>The total Joe would pay is</b>	<b>\$1,720</b>	<b>The total Mia would pay is</b>	<b>\$1,500</b>

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