

## 2025 Small Group Engage Overview

Engage Benefits	Platinum Engage \$500 w/Gym with Limited Service Area	Gold Engage \$1,500 w/Gym with Limited Service Area	Gold Engage \$3,500 w/Gym with Limited Service Area	Silver Engage \$4,000 w/Gym with Limited Service Area	Silver Engage \$7,000 w/ Gym with Limited Service Area	Silver Engage \$0 w/Gym with Limited Service Area
A <b>deductible (ded)</b> is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	\$500 / \$1,000	\$1,500 / \$3,000	\$3,500 / \$7,000	\$4,000 / \$8,000	\$7,000 / \$14,000	\$0 / \$0
What do I pay for covered benefits?				ment covers office visit ONLY. All other s then you pay the applicable coinsurance	ervices are subject to deductible and/or c (%) amount.	oinsurance.
Preventive Care	You pay \$0. Plan pa	ys 100% for clinical preven	tive health services such as	physical exam, colonoscopy and routine	immunizations.	
rimary Care Provider Visit	\$10	\$40	\$40	\$40	\$40	\$50
rgent Care	\$10	\$40	\$40	\$40	\$40	\$50
'irtual Care	No charge	No charge	No charge	No charge	No charge	No charge
pecialist Visit	\$30	\$90	\$90	\$90	\$90	\$100
lental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge	No charge
ab	No charge	No charge	No charge	\$50	\$50	\$100
-Ray	No charge	No charge	No charge	\$100	\$100	\$100
maging CT/PET/MRI	\$500	\$500	\$500	\$900	\$500	30%
mergency Room lans with copay (\$) all services are included	\$500	\$500	\$500	\$900	30%	\$1,500
ambulance Ground or Air	\$250	\$250	\$250	\$250	\$250	\$250
lospital Inpatient or Outpatient	20%	20%	20%	30%	30%	\$1,500 per day, 2-day max
hiropractic and Acupuncture imited to 20 visits each	\$10	\$40	\$40	\$40	\$40	\$50
ehabilitation Therapy hysical, Occupational and Speech	\$10	\$40	\$40	\$40	\$40	\$50
rescription Drugs per 30-day supply						
ier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge	No charge
ier 2: Non-Preferred Generic	\$5	\$5	\$5	\$25	\$25	\$25
er 3: Preferred Brand	\$15	\$15	\$15	\$75	\$50	\$50
ier 4: Non-Preferred Brand	\$100	\$100	\$100	\$150	30%	\$100
er 5: Specialty Pharmaceuticals	50%	50%	50%	50%	30%	50%
ut-of-Pocket Maximum includes the deductible,	copayments, coinsurance and	d prescription drug costs tl	nat you pay			
ne family out-of-pocket maximum is 2x ne individual out-of-pocket maximum.	\$3,500 / \$7,000	\$9,200 / \$18,400	\$9,200 / \$18,400	\$9,200 / \$18,400	\$9,200 / \$18,400	\$9,200 / \$18,400
Vellness and Other Services itness Center Membership	You and your appolled do	nondents (sees 19 and)	will have free access to me	are than 10,000 participating fitness conta	rc	
ision	You and your enrolled dependents (ages 18 and up) will have free access to more than 10,000 participating fitness centers.  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 BenefitSource 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 sum	·					

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 Group Subscriber Agreement and/or Summary of Benefits and Coverage, which can be found online at www.phs.org/formsanddocuments.