PRESBYTERIAN
Health Plan, Inc.

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 **deductible (ded)** 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 / $0
What do I pay for covered benefits?	**Copayment-Benefits with a copayment ($) 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	$50
Urgent Care	$10	$40	$40	$40	$40	$50
Virtual Care	No charge	No charge	No charge	No charge	No charge	No charge
Specialist Visit	$30	$90	$90	$90	$90	$100
Mental Health Outpatient Services	No charge	No charge	No charge	No charge	No charge	No charge
Lab	No charge	No charge	No charge	$50	$50	$100
X-Ray	No charge	No charge	No charge	$100	$100	$100
Imaging CT/PET/MRI	$500	$500	$500	$900	$500	30%
Emergency Room Plans with copay ($) all services are included	$500	$500	$500	$900	30%	$1,500
Ambulance Ground or Air	$250	$250	$250	$250	$250	$250
Hospital Inpatient or Outpatient	20%	20%	20%	30%	30%	$1,500 per day, 2-day max
Chiropractic and Acupuncture Limited to 20 visits each	$10	$40	$40	$40	$40	$50
Rehabilitation Therapy Physical, Occupational and Speech	$10	$40	$40	$40	$40	$50
Prescription Drugs per 30-day supply						
Tier 1: Preferred Generic	No charge	No charge	No charge	No charge	No charge	No charge
Tier 2: Non-Preferred Generic	$5	$5	$5	$25	$25	$25
Tier 3: Preferred Brand	$15	$15	$15	$75	$50	$50
Tier 4: Non-Preferred Brand	$100	$100	$100	$150	30%	$100
Tier 5: Specialty Pharmaceuticals	50%	50%	50%	50%	30%	50%
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.	$3,500 / $7,000	$9,200 / $18,400	$9,200 / $18,400	$9,200 / $18,400	$9,200 / $18,400	$9,200 / $18,400
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 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 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.