PRESBYTERIAN
Health Plan, Inc.

2022 Small Group HMO Overview

Bronze 1 is not Medicare Part D creditable.

HMO Benefits	Platinum 1	Platinum 2	Gold 3	HDHP Gold 4*	HDHP Silver 1*	Silver 3	Silver 4	Bronze 1
A **deductible** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$500	$0	$3,200	$3,200	$3,200	$2,500	$5,000	$8,700
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) 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	$10	$30	0%	20%	$40	$30	$40
Urgent Care	$10	$10	$30	0%	20%	$40	$30	$40
Video Visit	$0	$0	$0	0%	0%	$0	$0	$0
Specialist Visit	$30	$25	$90	0%	20%	$90	$90	0%
Mental Health Outpatient Services	$0	$0	$0	0%	20%	$0	$0	$0
Lab	$0	$0	$0	0%	20%	$50	$50	0%
X-Ray	$0	$0	$0	0%	20%	$100	$100	0%
Imaging CT/PET/MRI	$250	$100	$300	0%	20%	$750	$500	0%
Emergency Room Plans with copay ($) all services are included	$250	$100	$500	0%	20%	$1,000	$1,000	0%
Ambulance Ground or Air	20% air, $100 ground	20% air, $100 ground	20% air, $250 ground	0%	20%	30% air, $250 ground	30% air, $250 ground	0%
Hospital Inpatient or Outpatient	20%	$250 per day, up to a max of $750	20%	0%	20%	30%	30%	50% Not Subject to Deductible/0%
Chiropractic and Acupuncture Limited to 20 visits each	$10	$10	$30	0%	20%	$40	$30	$40
Rehabilitation Therapy Physical, Occupational and Speech	$10	$10	$30	0%	20%	$40	$30	$40
Prescription Drugs per 30-day supply								
Tier 1: Preferred Generic	$0	$0	$0	0%	0%	$0	$0	$0
Tier 2: Non-Preferred Generic	$10	$5	$15	0%	20%	$15	$15	$25
Tier 3: Preferred Brand	$20	$10	$60	0%	20%	$130	$130	0%
Tier 4: Non-Preferred Drug	$75	$50	$150	0%	20%	$150	$150	0%
Tier 5: Specialty Pharmaceuticals	20%	$250	20%	0%	20%	30%	30%	0%
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	$2,750	$5,500	$3,200	$7,000	$8,700	$8,700	$8,700
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 www.phs.org/formsanddocuments.

*** High Deductible Health Plans (HDHP)** - Qualified high deductible health plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified out-of-pocket medical expenses tax-free. To learn more, visit www.healthequity.com or call 1-866-346-5800.