PRESBYTERIAN 2021 HIX Group PPO Gold 1

Coverage for: Individual or Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-800-923-6980 or visit www.phs.org. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-923-6980 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1200/Individual / \$2400/Family Out-of-Network: \$2400/Individual / \$4800/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care and any benefit where there is no charge (except for HDHPs) are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive care</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In Network: \$8550 Individual / \$17100 Family. Out of Network: \$17100 Individual / \$34200 Family.	The <u>out of pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out of pocket limit</u> until the overall family <u>out of pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.phs.org or call 1-800-923-6980 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out of network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out of network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Information	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copayment</u> visit. <u>Copayment</u> is for office visit only, <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Video Visit-No charge. <u>Deductible</u> does not apply to <u>copayment</u> . <u>Copayment</u> is for office visit only, all other services <u>deductible</u> does apply.	
	Specialist visit	\$90 <u>copayment</u> /visit. <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	<u>Copayment</u> is for office visit only, all other services <u>deductible</u> does apply.	
	Preventive care/screening/immunization	No charge <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Drive outhorization is required or honofite mouths	
	Imaging (CT/PET scans, MRIs)	\$300 <u>copayment</u> per test <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. <u>Deductible</u> does not apply to <u>copayment</u> .	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at phs.org/formsanddocuments	Preferred Generic Drugs (Tier 1)	No charge <u>deductible</u> does not apply.	No charge <u>deductible</u> does not apply.		
	Non-Preferred Generic Drugs (Tier 2)	\$15 copayment (retail) / \$45 copayment (mail order) deductible does not apply.	\$15 copayment (retail) / \$45 copayment (mail order) deductible does not apply.	Tier 1, Tier 2, Tier 3 and Tier 4 covers up to a 30-day	
	Preferred Brand Drugs (Tier 3)	\$50 copayment (retail) / \$150 copayment (mail order) deductible does not apply.	\$50 <u>copayment</u> (retail) / \$150 <u>copayment</u> (mail order) <u>deductible</u> does not apply.	supply (retail prescription); 90-day supply (mail order prescription)Tier 5 Mail order is not covered. Prior authorization for some drugs will be required or benefits may be denied. Deductible does not apply to	
	Non-preferred drugs (Tier 4)	\$125 <u>copayment</u> (retail) / \$375 <u>copayment</u> (mail order) <u>deductible</u> does not apply.		copayment. Insulin or a Medically Necessary alternative will not exceed \$25.00 for a 30-day supp	
	Self-Administered Specialty (Tier 5)	20% <u>coinsurance</u> after <u>deductible</u> is met./ Not available (mail order)	Not Covered		

Common Medical Event	Services You May Need	What You	u Will Pay	Limitations, Exceptions, & Other Important	
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Information	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does apply.	
surgery	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does apply.	
If you need immediate medical attention	Emergency room care	\$500 copayment/visit deductible does not apply.	\$500 copayment/visit deductible does not apply.	Waived if admitted into a hospital, then hospital copayment or coinsurance will apply. Deductible does not apply to copayment. No charge for anything related to COVID-19 screening, testing, or medical treatment. Balance billing is not allowed for out-of-network care.	
	Emergency medical transportation	\$250 copayment/ground. 20% coinsurance/Air Ambulance after deductible is met.	\$250 copayment/ground. 20% coinsurance/Air Ambulance after deductible is met.	Deductible does not apply to copayment. No charge for anything related to COVID-19 screening, testing, or medical treatment. Balance billing is not allowed for out-of-network care.	
	<u>Urgent care</u>	\$30 <u>copayment</u> /visit. <u>deductible</u> does not apply.	\$30 <u>copayment</u> /visit. <u>deductible</u> does not apply.	Copayment is for office visit only. Deductible does not apply to copayment. No charge for anything related to COVID-19 screening, testing, or medical treatment. Balance billing is not allowed for out-of-network care.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does apply.	
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does apply.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copayment/visit. Copayment is for office visit only, deductible does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	All other services <u>deductible</u> does apply.	
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does apply.	

Common Medical Event	Services You May Need	What Yo	u Will Pay	Limitations, Exceptions, & Other Important	
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Information	
	Office visits	\$300 <u>copayment</u> /per pregnancy. <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Cost sharing does not apply for preventative services. Prior Authorization does not apply to maternity ultrasounds. Deductible does not apply to copayment.	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	<u>Deductible</u> does apply. Prior authorization does not apply to maternity ultrasounds.	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does apply. Prior authorization does not apply to maternity ultrasounds.	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Coverage is limited to 100 days/calendar year. Prior authorization is required or benefits may be denied. <u>Deductible</u> does apply.	
	Rehabilitation services	\$30 <u>copayment</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does not apply to copayment.	
	Habilitation services	\$30 <u>copayment</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Deductible does not apply to copayment.	
	Skilled nursing care	\$200 <u>copayment</u> /day. <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does not apply to copayment	
	Durable medical equipment	45% <u>coinsurance</u> after <u>deductible</u> is met.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Hearing aids are covered for school aged children under 21, if still attending high school every 36 months/hearing impaired ear. Deductible does apply.	
	Hospice services	\$200 <u>copayment</u> /day <u>deductible</u> does not apply.	50% <u>coinsurance</u> after <u>deductible</u> is met.	Prior authorization is required or benefits may be denied. Deductible does not apply to copayment.	

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Information	
If your child needs dental or eye care	Children's eye exam	No Charge deductible does not apply.	\$55.00 <u>copayment</u> <u>deductible</u> 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 <u>deductible</u> does not apply.	\$40.00 copayment deductible does not apply.	Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus is limited to once a year; additional charges may apply.	
	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 GSA 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 <u>plan</u> document.)

- Abortion Services (excepted and non-excepted)
- Chiropractic Care (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Routine Eye Care (Adult) limited to one eye exam per year only

- Acupuncture (20 visits per calendar year unless for rehabilitative or habilitative svc)
- Hearing Aids for school aged children
- Weight Loss Programs

Bariatric Surgery

Infertility Treatment

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>appeal</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>.

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 1-855-592-7737. Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-592-7737. 如果需要中文的帮助,请拨打这个号码 1-855-592-7737. Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-592-7737.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal c 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 plan's overall deductibleSpecialistHospital (Facility)Other	\$1200 \$90 20% 20%	The plan's overall deductibleSpecialistHospital (Facility)Other	\$1200 \$90 20% 20%	The plan's overall deductibleSpecialistHospital (Facility)Other	\$1200 \$90 20% 20%
This EXAMPLE event includes services Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia)	3	This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)		This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	
Total Example Cost	\$17,519.38	Total Example Cost	\$7,389.27	Total Example Cost	\$2,800.00
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	\$1,200.00	Deductibles	\$1,200.00	Deductibles	\$300.00
Copayments	\$300.00	Copayments	\$400.00	Copayments	\$1,200.00
Coinsurance	\$1,500.00	Coinsurance	\$700.00	Coinsurance	\$0.00
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$0.00	Limits or exclusions	\$0.00	Limits or exclusions	\$0.00
The total Peg would pay is	\$3,000.00	The total Joe would pay is	\$2,300.00	The total Mia would pay is	\$1,500.00

The **plan** would be responsible for the other costs of these EXAMPLE covered services.