




Coverage for: Individual or Family | Plan Type: PPO

 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 1-866-574-9567 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 1-866-574-9567 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>LoboCare/In-Network:  <b>\$600</b>/Individual /  <b>\$1,200</b>/Family                      Out-of-Network  <b>\$1,800</b>/Individual /  <b>\$3,600</b>/Family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">preventive care</a> is covered before you meet your <a href="#">deductible</a>.</p>	<p>This plan covers some items and services even if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan 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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>LoboCare/In-Network:  <b>\$3,000</b>/Individual /  <b>\$6,000</b>/Family                      Out-of-network:  <b>\$7,500</b>/Individual /  <b>\$15,000</b>/Family</p>	<p>The <a href="#">out of pocket limit</a> is the most you could pay in a year for covered services.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Premiums, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. In addition, certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act (ACA), and fall outside the out-of-pocket limits.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out of pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="https://www2.phs.org/providers?insurance_plans=unm-employees">https://www2.phs.org/providers?insurance_plans=unm-employees</a> or call 1-866-574-9567 for a list of participating providers.</p>	<p>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>).</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a referral.</p>



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
		Lobo Care Provider (You will pay the least)	In-network Provider	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	\$25 <a href="#">copayment</a> /visit Virtual Visits/Telehealth \$25 <a href="#">copayment</a> /visit	\$30 <a href="#">copayment</a> /visit Virtual Visits/Telehealth \$30 <a href="#">copayment</a> /visit	40% <a href="#">coinsurance</a> Virtual Visits/Telehealth Not Covered	<a href="#">Deductible</a> does not apply for <a href="#">copayment</a> . Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copayment</a> /visit Virtual Visits/Telehealth \$35 <a href="#">copayment</a> /visit	\$45 <a href="#">copayment</a> /visit Virtual Visits/Telehealth \$45 <a href="#">copayment</a> /visit	40% <a href="#">coinsurance</a> Virtual Visits/Telehealth Not Covered	<a href="#">Deductible</a> does not apply for <a href="#">copayment</a> . Prior Authorization is not required for gynecological or obstetrical ultrasounds.
	<a href="#">Preventive care/screening</a> /immunization	No charge	No charge	40% <a href="#">coinsurance</a> (No Copay if using a National Network Provider)	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	40% <a href="#">coinsurance</a>	LoboCare and In-network <a href="#">deductible</a> does not apply. Prior authorization/ Benefit certification may be required.
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lobo Care Provider (You will pay the least)	In-network Provider	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://www.caremark.com/">prescription drug coverage</a> is available at <a href="https://www.caremark.com/">https://www.caremark.com/</a>	Generic drugs (Tier 1)	\$10 <a href="#">copayment</a> (30-day retail) and \$20 <a href="#">copayment</a> (90-day retail and mail order)	\$10 <a href="#">copayment</a> (30-day retail) and \$20 <a href="#">copayment</a> (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable <a href="#">copayment</a> .	Tier 1, Tier 2 and Tier 3: Covers up to a 30-day supply (retail and mail order prescription); 90-day supply (mail order prescription). Not all drugs are covered or have quantity limits. For more info go to <a href="https://www.caremark.com/">https://www.caremark.com/</a> or call 1-877-745-4394  Tier 4 Specialty network: Must use CVS Specialty. Call 1-800-237-2767 or visit <a href="https://www.cvsspecialty.com/">https://www.cvsspecialty.com/</a> .
	Preferred brand drugs (Tier 2)	25% <a href="#">coinsurance</a> , \$35 to max \$70 (30-day retail) and 25% <a href="#">coinsurance</a> , \$87.50 to max \$175 (90-day retail and mail order)	25% <a href="#">coinsurance</a> , \$35 to max \$70 (30-day retail) and 25% <a href="#">coinsurance</a> , \$87.50 to max \$175 (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable <a href="#">copayment</a> .	
	Non-preferred brand drugs (Tier 3)	25% <a href="#">coinsurance</a> , \$55 to max \$110 (30-day retail) and 25% <a href="#">coinsurance</a> , \$137.50 to max \$275 (90-day retail and mail order)	25% <a href="#">coinsurance</a> , \$55 to max \$110 (30-day retail) and 25% <a href="#">coinsurance</a> , \$137.50 to max \$275 (90-day retail and mail order)	Responsible for 100% of cost, then reimbursed the contracted rate less applicable <a href="#">copayment</a> .	
	Specialty drugs (Tier 4)	20% <a href="#">coinsurance</a> to max \$250/ prescription. Copays for certain specialty medications may be set to the amount of any available manufacturer-funded copay assistance.	20% <a href="#">coinsurance</a> to max \$250/ prescription. Copays for certain specialty medications may be set to the amount of any available manufacturer-funded copay assistance.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lobo Care Provider (You will pay the least)	In-network Provider	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copayment</a> /visit	\$150 <a href="#">copayment</a> /visit	\$150 <a href="#">copayment</a> /visit	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a> emergency ground and air	25% <a href="#">coinsurance</a> emergency ground and air	25% <a href="#">coinsurance</a> emergency ground and air	No charge for inter-facility transfer ground and air.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> /visit Video visits-Not available	\$75 <a href="#">copayment</a> /visit Video visits-\$10 <a href="#">copayment</a>	40% <a href="#">coinsurance</a> Video visits-Not Covered	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copayment</a> /visit	\$10 <a href="#">copayment</a> /visit	40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> . Residential treatment centers limited to 60 days per year. Not covered by LoboCare providers. IOP, Inpatient, and partial hospitalization may require prior authorization/ benefit certification.
	Inpatient services	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Residential treatment centers limited to 60 days per year. Not covered by LoboCare providers. IOP, Inpatient, and partial hospitalization may require prior authorization/ benefit certification.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lobo Care Provider (You will pay the least)	In-network Provider	Out-of-network Provider (You will pay the most)	
If you are pregnant	Office visits	\$25 <a href="#">copayment</a> first visit only	\$30 <a href="#">copayment</a> first visit only	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for preventive services. Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required. Authorization is not required for gynecological or obstetrical ultrasounds.
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required. Authorization is not required for gynecological or obstetrical ultrasounds.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 days/plan year.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copayment</a> /visit	\$30 <a href="#">copayment</a> /visit	40% <a href="#">coinsurance</a>	Includes physical, speech, occupational, and hearing therapies (office or outpatient); Max of 70 visits combined. If determined medically necessary, additional visits may be approved.
	<a href="#">Habilitation services</a>	\$25 <a href="#">copayment</a> /visit	\$30 <a href="#">copayment</a> /visit	40% <a href="#">coinsurance</a>	Benefit Certification may be required.
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60 days/plan year.
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required.
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization/ Benefit certification may be required. LoboCare services are limited to pediatric hospice only.
If your child needs dental or eye care	Children's eye exam	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Covered under pediatric preventive services.
	Children's glasses	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not Covered
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li><li>• Dental check-up (Child)</li></ul>	<ul style="list-style-type: none"><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Private-Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine Eye Care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs (Unless for medically necessary treatment for morbid obesity)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Hearing Aids up to \$2,500 every 36 months per hearing impaired ear</li></ul>	<ul style="list-style-type: none"><li>• Non-Emergency Care When Traveling Outside the U.S.</li></ul>

**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](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 [appeal](#). Your [plan](#) documents also provide complete information 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 1-866-574-9567.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-574-9567.

如果需要中文的帮助, 请拨打这个号码 1-866-574-9567.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-574-9567.

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 plan's overall deductible	\$600	The plan's overall deductible	\$600	The plan's overall deductible	\$600
Specialist	\$45	Specialist	\$45	Specialist	\$45
Hospital (Facility)	25%	Hospital (Facility)	25%	Hospital (Facility)	25%
Other	25%	Other	25%	Other	25%
<p><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>)</p>		<p><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>)</p>		<p><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>)</p>	
<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>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$600	Deductibles	\$600	Deductibles	\$600
Copayments	\$40	Copayments	\$500	Copayments	\$400
Coinsurance	\$2,200	Coinsurance	\$700	Coinsurance	\$200
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,900</b>	<b>The total Joe would pay is</b>	<b>\$1,820</b>	<b>The total Mia would pay is</b>	<b>\$1,200</b>

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