



PHOEBE-DEVITT HOMES 2022 BENEFIT SUMMARY

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$600	\$3,000
Family	\$1,200	\$6,000
Plan Pays – payment based on the plan allowance	100% after deductible	60% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	N/A	\$5,000
Family	N/A	\$10,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$8,700	not applicable
Family	\$17,400	not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$40 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$30 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after \$40 copay	60% after deductible
Virtual Visit Originating Site Fee	100% after deductible	60% after deductible
Urgent Care Center Visits	100% after \$40 copay	60% after deductible
Telemedicine Services (3)	100% after \$10 copay	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	60% after deductible
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	60% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	60% after deductible
Nicotine Patches (Covered under Prescription Drug Benefits)	100% (deductible does not apply)	60% after deductible
Colorectal Screening, Routine	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	60% after deductible
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services	100% after \$175 copay (waived if admitted)	
Ambulance - Emergency	100% after in-network deductible	
Ambulance –Non-Emergency	100% after deductible	60% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	60% after deductible
Hospital Outpatient	100% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses – Excludes Neonatal Circumcision	100% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$40 copay	60% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	60% after deductible
Speech Therapy	100% after \$40 copay	60% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	100% after \$40 copay	60% after deductible
	limit: 12 visits/benefit period	

Benefit	In Network	Out of Network
Spinal Manipulations	100% after \$40 copay	60% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	60% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$30 copay	60% after deductible
Outpatient Substance Abuse Services	100% after \$30 copay	60% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	60% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	60% after deductible
	\$36,000/benefit period	
Assisted Fertilization Procedures	not covered	not covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	60% after deductible
Home Health Care	100% after deductible	60% after deductible
	limit: 90 visits/benefit period	
Hospice	100% after deductible	60% after deductible
	limit: 10 days/lifetime or 240 hours/lifetime for respite care	
Infertility Counseling, Testing and Treatment (6)	100% after deductible	60% after deductible
Private Duty Nursing	100% after deductible	60% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	60% after deductible
	limit: 100 days/benefit period	
Transplant Services	100% after deductible	60% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual	\$125 per person Retail	
Family	(deductible does not apply to Phoebe Pharmacy)	
Prescription Drug Program (8) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.	Retail Drugs (30-day Supply)	
	\$10 formulary generic copay	
	\$10 non-formulary generic copay	
	\$45 formulary brand copay	
	\$65 non-formulary brand copay	
Your plan uses the Precision Formulary with an Incentive Benefit Design	Specialty Rx are only covered through the Phoebe Pharmacy	
	\$250 copayment	
	Maintenance Drugs through Mail Order (90-day Supply)	
	Not Applicable	
NEW IN 2022: All maintenance medications are required to be filled through the Phoebe Pharmacy after the first fill at a non-Phoebe pharmacy and would be filled as a 90-day supply. Maintenance medications being filled at the Phoebe Pharmacy at a 30-day supply must be transitioned to a 90-day supply after the first fill	Please note that the \$125 deductible does not apply to the Phoebe Pharmacy. Also the Phoebe Pharmacy can dispense 90 day prescription with a tier structure of \$25 Generic/\$95 brand formulary/\$140 brand non-formulary.	
	(specialty drugs not available for a 90 day supply)	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
- (3) Services are provided for acute care for minor illnesses. Services must be performed by a Teladoc approved telemedicine provider. Virtual Behavioral Health visits provided by a Magellan approved telemedicine provider are eligible under the Outpatient Mental Health/Substance Abuse benefit.
- (4) Services are limited to those listed on the PPACA Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits. If the ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate.
- (6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (7) Magellan Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The Magellan formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Magellan Pharmacy Services and approved by the Magellan Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drug.

Expect more. Benefit more.

