FREQUENTLY ASKED QUESTIONS

Q: WHAT IS MY NETWORK?

A: The answer depends on the service. If you are seeking care from a doctor, a specialist or looking for an urgent care facility, then you would utilize the PHCS network. For hospital services, including emergency room services, your Plan uses an open network whereby every hospital facility is eligible to deliver services to you and your family.

Q: WHAT DO I DO IF MY DOCTOR'S OFFICE SAYS THEY DON'T ACCEPT MY COVERAGE?

A: Provide the S&S Administrators contact information from your ID card and ask that your doctor's office call them directly to verify your coverage.

Q: CAN I GET A ROUTINE X-RAY OR LAB WORK DONE AT A HOSPITAL?

A: No. Any elective (scheduled) diagnostic services must be performed in a freestanding facility. Diagnostic services and tests will not be covered in a hospital setting unless deemed an emergency OR pre-approved by S&S Administrators due to lack of freestanding facility access within a 50-mile radius of the Participant's residence.

Q: WHAT LABS ARE CONSIDERED IN-NETWORK?

A: LabCorp and Quest are both In-Network labs.

Q: WHAT IS A FREE-STANDING FACILITY?

A: A free-standing facility is operated by a licensed physician and approved by Medicare to perform specialized diagnostic and radiologic tests and is neither integrated with nor a department of a hospital. Free-standing diagnostic imaging centers are equipped with advanced diagnostic technology and deliver high-quality, cost-effective testing results.

Q: IS S&S ADMINISTRATORS HEALTH MY HEALTH CARRIER/PLAN?

A: No. S&S Administrators is the third-party administrator responsible for paying claims, providing call center support, administering preauthorization, and other important tasks critical to the smooth operation of your health plan. The Plan is referred to as The Health Benefit Alliance(HBA).

Q: WHAT DO I DO IF THE HOSPITAL STATES THEY ARE NOT CONTRACTED WITH PHCS?

A: Your Plan uses an open network for hospital care whereby every hospital facility is eligible to deliver services to you and your family.

FREQUENTLY ASKED QUESTIONS

Q: WHAT DO I DO IF I RECEIVE A BALANCE BILL FOR A HOSPITAL-BASED SERVICE?

A: The Participant should contact the S&S Administrators to initiate the balance bill support process (see page 6 of this Participant Guide).

Q: WHAT SHOULD I DO IF I DO NOT HAVE MY PHYSICAL ID CARD IN HAND FOR A DOCTOR'S VISIT?

A: You can download your virtual ID card from the S&S Administrators Member portal (see registrationinstructions on page 3 of this Participant Guide).

Q: ARE DOMESTIC PARTNERS COVERED UNDER MY PLAN?

A: No. Domestic Partners are not eligible for coverage under any HBA plans.

Q: WHAT IS THE AGE LIMIT FOR DEPENDENT CHILDREN UNDER MY PLAN?

A: Dependent coverage terminates at the end of the month in which the dependent child turns age 26.

Q: IS BARIATRIC SURGERY COVERED UNDER MY PLAN?

A: No. Bariatric surgery is not a covered service under any of the HBA plans.

Q: DOES MY PLAN PROVIDE MATERNITY COVERAGE FOR DEPENDENT CHILDREN?

A: No. HBA plans do not provide maternity coverage for dependent children.

Q: DOES MY PLAN COVER INFERTILITY TREATMENT?

A: No. Infertility treatment is not covered under any HBA plans.

Q: WILL COVID-19 TESTS BE COVERED UNDER MY PLAN?

A: Yes. HBA plans will cover verified home tests under the pharmacy benefit, at no cost to the Participant, up to the federal requirement of eight (8) per person.

Q: ARE ROUTINE PODIATRIC SERVICES COVERED UNDER MY PLAN?

A: No. Routine foot care, including orthotics, is not covered under any HBA plans.

Q: ARE NON-US CITIZENS ELIGIBLE FOR COVERAGE UNDER AN HBA PLAN?

A: Yes. Regardless of citizenship status, Participants with a Social Security Number (SSN) or Individual Tax Identification Number (ITIN) may be covered under an HBA plan.

FREQUENTLY ASKED QUESTIONS

Q: DO ANY OF THE HBA PLANS COVER PEDIATRIC DENTAL OR VISION?

A: No. HBA plans do not provide pediatric dental or vision coverage.

Q: DO HBA PLANS COVER TREATMENT OR PROCEDURES TO CHANGE ONE'S PHYSICAL ANATOMY TO THAT OF THE OPPOSITE SEX?

A: No. HBA plans do not cover gender affirming surgery or surgical procedures for the treatment of gender dysphoria.

Q: DO HBA PLANS COVER TREATMENT FOR SEXUAL DYSFUNCTION?

A: No. Treatment for sexual dysfunction is not a covered service.

Q: WILL MY PLAN COVER SERVICES FOR THE DIAGNOSIS OR TREATMENT FOR SLEEP APNEA?

A: No. HBA plans do not provide coverage for the diagnosis or treatment of sleep apnea, including CPAP machines.

Q: DO HBA PLANS COVER PRIVATE DUTY NURSING OR SKILLED NURSING FACILITIES?

A: No. HBA plans do not cover Private Duty Nursing or Skilled Nursing Facilities.

Q: IS THERE A WEBSITE I CAN ACCESS TO SEE MY BENEFIT INFORMATION?

A: Yes. The S&S Administrators Member portal provides benefit and other import information about your Plan (see registration instructions on page 3 of this Member Guide).

GLOSSARY OF HEALTH PLAN TERMS

COPAY: A fixed amount you pay for a covered service. For example, copays may apply to office visits, urgent care, emergency room services, hospital admissions or ancillary services. While copays will not satisfy any part of a Plan's deductible, they do accrue toward the Plan's Out-of-Pocket Maximum Limit. Copays should not apply to any preventative services.

COINSURANCE: The Plan's share of the cost of covered services, calculated as a percentage of the allowed amount. This percentage is applied after any applicable deductible or copay have been met. You pay any remaining percentage of the cost until the Plan's Out-of-Pocket Maximum is met. Coinsurance percentages will differ between In-Network and Out-of-Network services.

DEDUCTIBLE: The amount you pay before benefits for covered services begin. Benefits for covered services subject to the deductible will not commence until the deductible has been met. Deductibles do not apply to any preventative services, as required under the Affordable Care Act (ACA).

EMERGENCY ROOM: A hospital room or area staffed and equipped for the reception and treatment of persons requiring immediate medical care.

MEDICALLY NECESSARY: Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

NETWORK PROVIDER: A health care professional who has a contract with your health plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for the same services.

OUT-OF-POCKET MAXIMUM: The most you will pay during a set period of time before your Plan begins to pay 100% of the allowed amount for covered services. Deductibles, coinsurance, and copays are included in the out-of-pocket maximum.

PREAUTHORIZATION: A process by which your health plan determines if a service, treatment plan, prescription drug or durable medical equipment device is medically necessary. Sometimes called prior authorization, prior approval or precertification, preauthorization is required for certain services including, but not limited to, surgeries, advanced imaging, and non-emergency in-patient services over $1,000.

PRESCRIPTION DRUGS: Each Plan offers its own unique formulary, or schedule of covered prescription drugs. Specific copays may apply depending on the nature of the prescription drug (e.g., generic, brand name, specialty, etc.). The retail pharmacy benefit generally provides for up to a 21- or 30-day supply. Mail order prescriptions allow for up to a 90-day supply.

GLOSSARY OF HEALTH PLAN TERMS

PREVENTIVE SERVICES: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Services coded as preventive are covered 100% without a deductible, coinsurance, or copay.

REFERENCE BASED PRICING (RBP): A process by which the Plan pays providers a percentage above what Medicare would have paid for the same service. RBP fairly compensates the facility for the services rendered while helping control health plan costs. As long as participants adhere to Plan rules and pre-authorization requirements, they will not be responsible for charges for covered services in excess of applicable Plan copays, coinsurance or deductibles.

USUAL, CUSTOMARY & REASONABLE (UCR): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

URGENT CARE: Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.