PRESBYTERIAN

Offered by Presbyterian Insurance Company

PREFERRED CARE (Large Group)

PPO Benefit Plans

Benefit	PPO Plans – IIP: 10015, 10003, 10004, 10005, 10006, 10007		PPO Plans – IIP: 10008, 10009, 10010, 10011, 10012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible (Deductible must be met before payments are made)	IIP10015 = $250 IIP10003 = $500 IIP10004 = $750 IIP10005 = $1,000 IIP10006 = $1,500 IIP10007 = $2,000 3X family	IIP10015 = $500 IIP10003 = $1,000 IIP10004 = $1,500 IIP10005 = $2,000 IIP10006 = $3,000 IIP10007 = $4,000 3X family	IIP10008 = $500 IIP10009 = $750 IIP10010 = $1,000 IIP10011 = $1,500 IIP10012 = $2,000 3X family	IIP10008 = $1,000 IIP10009 = $1,500 IIP10010 = $2,000 IIP10011 = $3,000 IIP10012 = $4,000 3X family
Annual Out-of-Pocket Maximum (Does **not** include Deductible)	$2,000 3X family	$6,000 3X family	$4,500 3X family	$10,000 3X family
Lifetime Maximum Benefit	$5 million combined In-network and Out-of-network			
Maximum Lifetime Hospice Benefit	$7,500 combined In-network and Out-of-network			
Maximum Lifetime Transplant Benefit [1] Must use PIC approved facilities	Subject to Maximum Lifetime Benefit	**Not Covered**	Subject to Maximum Lifetime Benefit	**Not Covered**
Pre-Existing Limitation (Does not apply to pregnancy, newborns and newly adopted children)	• No pre-existing limitation if prior creditable coverage • New Hires: 6/6 • Late Enrollees: 6/18			
Physician Services				
Non-Specialist office visits	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Specialist office visits	$30 Copay/visit [2, 3]	40%	$40 Copay/visit [2, 3]	50%
Outpatient Surgery (In Physician's office)	20%	40%	30%	50%
Specialty Pharmaceuticals [1] (Injectible forms administered in Physician's office)	15% up to a maximum of $250 per injection and $1,500 per Calendar Year	15% up to a maximum of $250 per injection	15% up to a maximum of $250 per injection and $1,500 per Calendar Year	15% up to a maximum of $250 per injection
Allergy Services				
Testing	20%	40%	30%	50%
Serum (extracts)	20%	40%	30%	50%
Injections	20%	40%	30%	50%
Clinical Preventive Services such as, but not limited to:				
Routine Physicals	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Adult Immunizations	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Child Immunizations	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Well Child Care	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Pap Smear	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Mammography	$0 Copay [2]	40%	$0 Copay [2]	50%
Colonoscopy	$0 Copay [2]	40%	$0 Copay [2]	50%
Women's Healthcare				
Gynecological Care	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
In office/Obstetrical/Maternity Care	$20 Copay/visit [2, 3]	40%	$30 Copay/visit [2, 3]	50%
Delivery [1]	20%	40%	30%	50%
Diabetes Services				
Diabetes Education and Office Visits (OV)	Included in OV Copay	40%	Included in OV Copay	50%
Hospital Outpatient Services				
Surgeries [1]	20%	40%	30%	50%
Diagnostic Tests: X-Ray [1]	20%	40%	30%	50%
Diagnostic Tests: Lab	$0	40%	$0	50%

[1] Benefit Certification may be required. [2] Not subject to or counted toward Deductible [3] Copayment is for the office visit **only.** All other services received during the office visit are subject to Deductible and Coinsurance.

This summary of Covered Benefits and services is subject to the provisions of the Group Subscriber Agreement and cannot modify or affect the Group Subscriber Agreement in any way, nor shall you accrue any rights because of any statement in or omission from this summary.

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Inpatient Services [1]				
Room & Board	20%	40%	30%	50%
Inpatient Physician Care	20%	40%	30%	50%
Hospice Care [1]	20%	40%	30%	50%
Accidental Injury/Urgent/Emergency Care				
Emergency Care including trauma	20%	20% Initial treatment only 40% follow-up care	30%	30% Initial treatment only 50% follow-up care
Urgent Care	$30 [3]	$30 [3] Initial treatment only 40% follow-up care	$40 [3]	$40 [3] Initial treatment only 50% follow-up care
Ambulance Services	20%		30%	
Complementary Therapies				
Acupuncture ($1,500/Calendar Year maximum)	20%	**Not Covered**	30%	**Not Covered**
Chiropractic Services ($1,500/Calendar Year maximum)	20%	**Not Covered**	30%	**Not Covered**
Mental Health Services [1]				
Outpatient	$30 Copay/visit [2, 3]	40%	$40 Copay/visit [2, 3]	50%
Inpatient/Partial Hospitalization	20%	40%	30%	50%
Rehabilitation Services				
Cardiac and Pulmonary Rehabilitation	20%	40%	30%	50%
Occupational, physical and speech therapy [1] (up to two months per condition per Calendar Year)	20%	40%	30%	50%
Durable Medical Equipment, Prosthetics, Appliances [1]	20%	40% ($1,000/ Calendar Year Maximum- Diabetic supplies do not count toward the Calendar Year Maximum benefit.)	30%	50% ($1,000/ Calendar Year Maximum- Diabetic supplies do not count toward the Calendar Year Maximum benefit.)
Transplants [1]	20%	**Not Covered**	30%	**Not Covered**
Prescription Drugs [1, 2]	**Optional Benefit Drug Riders**			
Generic (Preferred)	$7, 10, 15	**Not Covered**	$7, 10, 15	**Not Covered**
Brand (Preferred)	$20, 25, 30, 35		$20, 25, 30, 35	
Brand when generic is available	Generic copay + cost difference		Generic copay + cost difference	
Non-Preferred	$40, 45, 50, 55		$40, 45, 50, 55	
Diabetic supplies Brand/Generic/Non-Preferred	$7, 10, 15 / $20, 25, 30, 35 / $40, 45, 50, 55		$7, 10, 15 / $20, 25, 30, 35 / $40, 45, 50, 55	
Prepackaged items Brand/Generic/Non-Preferred	$7, 10, 15 / $20, 25, 30, 35 / $40, 45, 50, 55		$7, 10, 15 / $20, 25, 30, 35 / $40, 45, 50, 55	
Specialty Pharmaceuticals [1]	15% up to $250 per prescription and $1,500 per Calendar Year		15% up to $250 per prescription and $1,500 per Calendar Year	
Alcohol/Substance Abuse [1]	**Optional Benefit Substance Abuse Riders**			
Inpatient or Partial Hospitalization (up to 30 days per Calendar Year)	20%	40%	30%	50%
Outpatient (up to 30 visits per Calendar Year)	20%	40%	30%	50%

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