PRESBYTERIAN

offered by Presbyterian Insurance Company, Inc.

ADVANTAGE CARE HDHP (Small Group)
PPO Benefit Plans

Benefit	PPO Plans IIP: 10022, 10023, 10024, 10025			
	In-Network		Out-of-Network	
Annual Calendar Year Deductible (Deductible must be met before payments are made - includes pharmacy)	Individual 10022 $1,200 10023 $2,500 [3] 10024 $2,500 10025 $5,000 [3]	Family $2,400 $5,000 [3] $5,000 $10,000 [3]	Individual 10022 $2,500 10023 $5,000 10024 $5,000 10025 $10,000	Family $5,000 $10,000 $10,000 $20,000
Annual Out-of-Pocket Maximum (Includes Deductible)	Individual 10022 $2,400 10023 $2,500 [3] 10024 $4,000 10025 $5,000 [3]	Family $5,000 $5,000 [3] $8,000 $10,000 [3]	Individual 10022 $5,000 10023 $10,000 10024 $8,000 10025 $20,000	Family $10,000 $20,000 $16,000 $40,000
Lifetime Maximum	$5 million combined in and out-of-network			
Maximum Lifetime Hospice Benefit	$7,500 combined in and out-of-network			
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%		40%	
Specialist office visits	20%		40%	
Outpatient Surgery (In Physician's office)	20%		40%	
Specialty Pharmaceuticals [1] (Injectable forms administered in Physician's office)	15% up to a max. of $250 per injection		15% up to a max. of $250 per injection	
Allergy Services				
Testing	20%		40%	
Serum (extracts)	20%		40%	
Injections	20%		40%	
Clinical Preventive Services [2] - such as but not limited to: Routine Physicals Adult Immunizations Child Immunizations Well Child Care Routine Mammography/Pap Smear	Plan pays 100% Prescription Drugs are not included in Clinical Preventive Services and are therefore subject to the Deductible and applicable Co-insurance.		40%	
Women's Health Care				
Gynecological Care	20%		40%	
In office Obstetrical/Maternity Care	20%		40%	
Delivery [1]	20%		40%	
Diabetes Services				
Diabetes Education and Office Visits	20%		40%	

[1] Benefit Certification may be required. [2] Not subject to Deductible [3] The Plan pays 100% of all covered charges for In-Network Services, after the Deductible is met. Member is still responsible for Out-of-Network Deductible/Co-insurance and charges above Reasonable and Customary.
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**
Hospital Outpatient Services		
Surgeries [1]	20%	40%
Diagnostic Tests: Lab and X-Ray [1]	20%	40%
Hospital Inpatient Services [1]		
Room & Board	20%	40%
Inpatient Physician Care	20%	40%
Hospice Care [1]	20%	40%
Accidental Injury/Urgent/ Emergency Care		
Emergency Care including trauma	20%	20% Initial treatment only, 40% follow-up care
Urgent Care	20%	20% Initial treatment only, 40% follow-up care
Ambulance Services	20%	40%
Complementary Therapies		
Acupuncture ($1,500/Calendar Year maximum)	20%	**Not Covered**
Chiropractic ($1,500/Calendar Year maximum)	20%	**Not Covered**
Mental Health Services [1]		
Outpatient	20%	40%
Inpatient/Partial Hospitalization	20%	40%
Rehabilitation Services		
Cardiac and Pulmonary Rehabilitation	20%	40%
Occupational, physical and speech therapy [1] (up to 2 months per condition per Calendar Year)	20%	40%
Durable Medical Equipment, Prosthetics, Appliances [1]	20%	40% ($1,000/Calendar Year Maximum –) Diabetic supplies do not count toward the Calendar Year Maximum benefit)
Transplants [1]	20%	**Not Covered**
Prescription Drugs		**Not Covered (must use Participating Pharmacy)**
Generic/Brand/Non-Preferred	20% / 20% / 30%	
Diabetic Supplies Brand/Generic/Non-Preferred	20% / 20% / 30%	
Prepackaged Items Brand/Generic/Non-Preferred	20% / 20% / 30%	
Specialty Pharmaceuticals [1]	15% up to $250 per prescription	
Alcoholism/Substance Abuse [1]		
Detoxification Only	20%	40%

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