PRESBYTERIAN
Health Plan, Inc.

Updated 10/4/18

2019 Small Group HMO Overview

Gold 4, Silver and Bronze plans are not Medicare Part D creditable.

HMO Benefits	Platinum	Gold 1	Gold 2	Gold 3	HDHP Gold 4*	HDHP Silver 1*	Silver 2	Silver 3	Silver 4	Bronze 1	HDHP Bronze 2*	Bronze 3
A **deductible** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$100	$1,000	$5,000	$2,000	$2,800	$2,800	$1,000	$2,500	$5,000	$7,900	$6,600	$7,900
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) are *not* subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and or coinsurance. Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**											
Preventive Care	You pay $0 (in-network only). Presbyterian Health Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy, and routine immunizations.											
Primary Care Provider Visit	$5	$10	$10	$10	0%	20%	$20	$20	$20	$20	0%	0%
Urgent Care	$5	$10	$10	$10	0%	20%	$20	$20	$20	$20	0%	0%
Video Visit	$0	$0	$0	$0	0%	0%	$0	$0	$0	$0	0%	$0
Specialist Visit	$20	$75	$75	$75	0%	20%	$120	$120	$120	0%	0%	0%
Mental Health Outpatient Services	$5	$10	$10	$10	0%	20%	$20	$20	$20	$20	0%	0%
Lab	$0	$0	$0	$0	0%	20%	$25	$0	$0	0%	0%	0%
X-Ray	$0	$0	$0	$0	0%	20%	$100	$100	$100	0%	0%	0%
Imaging CT/PET/MRI	$50	$300	$300	$300	0%	20%	$750	$750	$750	0%	0%	0%
Emergency Room Plans with copay ($) all services are included	$100	$500	$500	$500	0%	20%	$1,000	$1,000	$1,000	$1,500	0%	0%
Ambulance Ground or Air	20%	20%	20%	20%	0%	20%	40%	30%	30%	0%	0%	0%
Hospital Inpatient and Outpatient	20%	20%	20%	20%	0%	20%	40%	30%	30%	0%	0%	0%
Chiropractic and Acupuncture Limited to 20 visits each	$10	$20	$20	$20	0%	20%	$30	$30	$30	0%	0%	0%
Rehabilitation Therapy Physical, Occupational and Speech	$20	$30	$30	$30	0%	20%	$40	$40	$40	0%	0%	0%
Prescription Drugs per 30 day supply												
Tier 1: Preferred Generic	$0	$0	$0	$0	0%	0%	$0	$0	$0	$0	0%	0%
Tier 2: Non-Preferred Generic	$5	$15	$15	$15	0%	20%	$15	$15	$15	$50	0%	0%
Tier 3: Preferred Brand	$10	$50	$50	$50	0%	20%	$130	$130	$130	0%	0%	0%
Tier 4: Non-Preferred Drug	$75	$125	$125	$125	0%	20%	$150	$150	$150	0%	0%	0%
Tier 5: Specialty Pharmaceuticals	20%	20%	20%	20%	0%	20%	40%	30%	30%	0%	0%	0%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance, and prescription drug costs that you pay												
The family out-of-pocket maximum (OOP) is 2x the individual OOP	$6,600	$7,900	$7,900	$5,000	$2,800	$6,600	$7,900	$7,900	$7,900	$7,900	$6,600	$7,900
Wellness and Other Services												
Fitness Center Membership	You and your enrolled dependents (ages 18 and up) will have *free* access to more than 10,000 participating fitness centers.											
Vision	We have partnered with VSP to provide vision coverage for you and your family. See the VSP flyer for Pediatric, Standard, and buy-up options. (*Underwritten and administered by Vision Service Plan (VSP)*)											
Dental	We have partnered with DentalSource Dental Plan, Inc. to offer dental coverage for you and your family. See the dental flyer for details. (*Underwritten and administered by Companion Life Insurance Company*)											

The benefit information provided is a brief summary, not a comprehensive description of benefits, limitations and/or exclusions. For more information, contact the plan at 1-800-356-2219 or refer to the Subscriber Agreement and/or Summary of Benefits Coverage, which can be found online at www.phs.org/formsanddocuments.

***High Deductible Health Plans (HDHP)** - Qualified high deductible health plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified out-of-pocket medical expenses tax-free. To learn more, visit www.healthequity.com or call 1-866-346-5800.

PRESBYTERIAN
Insurance Company, Inc.

Updated 10/4/18

2019 Small Group PPO Overview

Gold 4, Silver and Bronze plans are not Medicare Part D creditable.

PPO Benefits	Platinum		Gold 1		Gold 2		Gold 3		HDHP Gold 4*		HDHP Silver 1*		Silver 2		Silver 3		Silver 4		Bronze 1		HDHP Bronze 2*		Bronze 3	
A **deductible** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x individual deductible.	$100	$200	$1,000	$2,000	$5,000	$10,000	$2,000	$4,000	$2,800	$5,600	$2,800	$5,600	$1,000	$2,000	$2,500	$5,000	$5,000	$10,000	$7,900	$15,800	$6,600	$13,200	$7,900	$15,800
What do I pay for covered benefits?	**Copayment – Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit ONLY. All other services are subject to deductible and or coinsurance. Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.**																							
Preventive Care	You pay $0 (in-network only). Presbyterian Health Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy, and routine immunizations.																							
Primary Care Provider Visit	$5	50%	$10	50%	$10	50%	$10	50%	0%	0%	20%	50%	$20	50%	$20	50%	$20	50%	$20	0%	0%	0%	0%	0%
Urgent Care	$5	$5	$10	$10	$10	$10	$10	$10	0%	0%	20%	20%	$20	$20	$20	$20	$20	$20	$20	$20	0%	0%	0%	0%
Video Visit	$0	50%	$0	50%	$0	50%	$0	50%	0%	0%	0%	50%	$0	50%	$0	50%	$0	50%	$0	0%	0%	0%	$0	0%
Specialist Visit	$20	50%	$75	50%	$75	50%	$75	50%	0%	0%	20%	50%	$120	50%	$120	50%	$120	50%	0%	0%	0%	0%	0%	0%
Mental Health Outpatient Services	$5	50%	$10	50%	$10	50%	$10	50%	0%	0%	20%	50%	$20	50%	$20	50%	$20	50%	$20	0%	0%	0%	0%	0%
Lab	$0	50%	$0	50%	$0	50%	$0	50%	0%	0%	20%	50%	$25	50%	$0	50%	$0	50%	0%	0%	0%	0%	0%	0%
X-Ray	$0	50%	$0	50%	$0	50%	$0	50%	0%	0%	20%	50%	$100	50%	$100	50%	$100	50%	0%	0%	0%	0%	0%	0%
Imaging CT/PET/MRI	$50	50%	$300	50%	$300	50%	$300	50%	0%	0%	20%	50%	$750	50%	$750	50%	$750	50%	0%	0%	0%	0%	0%	0%
Emergency Room Plans with copay ($) all services are included	$100	$100	$500	$500	$500	$500	$500	$500	0%	0%	20%	20%	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,500	$1,500	0%	0%	0%	0%
Ambulance Ground or Air	20%	20%	20%	20%	20%	20%	20%	20%	0%	0%	20%	20%	40%	40%	30%	30%	30%	30%	0%	0%	0%	0%	0%	0%
Hospital Inpatient and Outpatient	20%	50%	20%	50%	20%	50%	20%	50%	0%	0%	20%	50%	40%	50%	30%	50%	30%	50%	0%	0%	0%	0%	0%	0%
Chiropractic and Acupuncture Limited to 20 visits each	$10	50%	$20	50%	$20	50%	$20	50%	0%	0%	20%	50%	$30	50%	$30	50%	$30	50%	0%	0%	0%	0%	0%	0%
Rehabilitation Therapy Physical, Occupational and Speech	$20	50%	$30	50%	$30	50%	$30	50%	0%	0%	20%	50%	$40	50%	$40	50%	$40	50%	0%	0%	0%	0%	0%	0%
Prescription Drugs per 30 day supply																								
Tier 1: Preferred Generic	$0	$0	$0	$0	$0	$0	$0	$0	0%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	$0	0%	0%	0%	0%
Tier 2: Non-Preferred Generic	$5	$5	$15	$15	$15	$15	$15	$15	0%	0%	20%	20%	$15	$15	$15	$15	$15	$15	$50	$50	0%	0%	0%	0%
Tier 3: Preferred Brand	$10	$10	$50	$50	$50	$50	$50	$50	0%	0%	20%	20%	$130	$130	$130	$130	$130	$130	0%	0%	0%	0%	0%	0%
Tier 4: Non-Preferred Drug	$75	$75	$125	$125	$125	$125	$125	$125	0%	0%	20%	20%	$150	$150	$150	$150	$150	$150	0%	0%	0%	0%	0%	0%
Tier 5: Specialty Pharmaceuticals	20%	20%	20%	20%	20%	20%	20%	20%	0%	0%	20%	20%	40%	40%	30%	30%	30%	30%	0%	0%	0%	0%	0%	0%
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance, and prescription drug costs that you pay																								
The family out-of-pocket maximum (OOP) is 2x the individual OOP	$6,600	$13,200	$7,900	$15,800	$7,900	$15,800	$5,000	$10,000	$2,800	$5,600	$6,600	$13,200	$7,900	$15,800	$7,900	$15,800	$7,900	$15,800	$7,900	$15,800	$6,600	$13,200	$7,900	$15,800
Other Services																								
Fitness Center Membership	You and your enrolled dependents (ages 18 and up) will have free access to more than 10,000 participating fitness centers, see fitness flyer for details.																							
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