


PRESBYTERIAN HEALTH PLAN
Custom Care HMO Plans — Large Group
Copay Options

Benefits	\$10 (HHH10084)	\$15 (HHH10085)	\$20 (HHH10087)	\$30 (HHH10089)	\$40 (HHH10101)
Annual Calendar Year Deductible	None				
Annual Out-of-Pocket Maximum	2x Annual Premium				
Physician Services					
Primary Care Physician (PCP) office visit	\$10	\$15	\$20	\$30	\$40
Specialist office visit	\$20	\$25	\$30	\$40	\$50
Preventive Services	\$0				
Hospital¹ (per visit)					
Inpatient	\$250	\$250	\$500	\$1,000	\$1,500
Outpatient	10% up to \$150	10% up to \$150	15% up to \$250	15% up to \$300	20% up to \$400
Urgent Care (Participating Provider) (Non-Participating Provider)	\$20 \$30	\$25 \$35	\$30 \$40	\$40 \$50	\$50 \$60
Emergency Care	\$75	\$100		\$150	
Diagnostic Tests¹ (lab and x-ray only)	\$0				
Acupuncture and Chiropractic (limited sessions)	\$20	\$25	\$30	\$40	\$50
Transplants¹	\$250		\$500	\$1,000	\$1,500
Vision	Refer to Optional Benefit Rider Materials				
Prescription Benefit Options¹	Refer to Optional Benefit Rider Materials				

¹Benefit Certification will be required.

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. Refer to the Schedule of Benefits or Group Subscriber Agreement for more details on all Covered Benefits and Exclusions.

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Eff. 1/1/11