PRESBYTERIAN HEALTH PLAN

Value Care HMO Plans — Small Group

Benefits	Copay Options			
	$15 (HHH10027/HHH10085)	$20 (HHH10029/HHH10087)	$30 (HHH10031/HHH10089)	$40 (HHH10053/HHH10101)
Annual Calendar Year Deductible	None			
Annual Out-of-pocket Maximum	2x Annual Premium			
Physician Services Non-Specialist office visit Specialist office visit	 $15 $25	 $20 $30	 $30 $40	 $40 $50
Preventive Services	$0			
Hospital[1] *(per visit)* Inpatient Outpatient	 $250 10% up to $150	 $500 15% up to $250	 $1,000 15% up to $300	 $1,500 20% up to $400
Urgent Care *(Participating Provider)* *(Non-Participating Provider)*	 $25 $35	 $30 $40	 $40 $50	 $50 $60
Emergency Care	$100		$150	
Diagnostic Tests[1] *(lab & x-ray only)*	$0			
Acupuncture and Chiropractic *(limited sessions)*	$25	$30	$40	$50
Transplants[1]	$250	$500	$1,000	$1,500
Vision	Refer to Optional Benefit Rider Materials			
Prescription Benefit Options[1] Retail/Mail-Order Generic (Preferred) Brand (Preferred) Non-Preferred	 $7 / 2x $17 / 2.5x $37 / 3x	 $10 / 2x $20 / 2.5x $40 / 3x	 $10 / 2x $35 / 2.5x $55 / 3x	 $10 / 2x $35 / 2.5x $55 / 3x

[1]Benefit 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.