PRESBYTERIAN INSURANCE COMPANY INC.

PresElect PPO Plans — Small Group

	Options	In-Network	Out-of-Network
Step 1: Elect an Annual Deductible			
The calendar year deductible must be met before payments are made. In-network and out-of-network deductibles are separate accumulations. Family deductible is three times the individual deductible listed.	Option 1	$500	$1,000
	Option 2	$1,000	$2,000
	Option 3	$2,000	$4,000
	Option 4	$2,500	$5,000
	Option 5	$3,500	$7,000
	Option 6	$5,000	$10,000
	Option 7	$7,500	$15,000
	Option 8	$10,000	$20,000
Step 2: Elect a Co-Insurance Level			
*Option 1 is only available with in-network deductibles of $3,500 or higher	Option 1*	0%	30%
	Option 2	20%	40%
	Option 3	30%	50%
Step 3: Elect an Out-of-Pocket Maximum			
The out-of-pocket maximum must be equal to or greater than the selected deductible. The out-of-pocket maximum does not include the deductible, copayments, penalties, non-covered charges, or prescription copayments. In-network and out-of-network maximums are separate accumulations.			
If you selected 0% co-insurance:	Out-of-Pocket maximum equals selected deductible		
If you selected 20% or 30% co-insurance, choose one: Family out-of-pocket maximum is three times the individual maximum	Option 1	$2,000	$4,000
	Option 2	$3,000	$6,000
	Option 3	$4,000	$8,000
	Option 4	$5,000	$10,000
	Option 5	$10,000	$20,000
Step 4: Elect a Pharmacy Benefit Level			
Copayments are for Preferred Generic/ Preferred Brand/Non-Preferred	Option 1	$5/$35/$50	
	Option 2	$10/$50/$75	
	Option 3	$10/$50*/$75*	(*combined $250 deductible)
Step 5 (optional): Add an Office Visit Copayment Benefit			
Office Visit Copayment	Adult	$20	Equal to selected deductible/co-insurance
	Child	$10	

See reverse side for a summary of In-Network and Out-of-Network benefits.

A six-month pre-existing limitation applies for all members 19 years of age or older. This may be reduced or eliminated with proof of prior creditable coverage.

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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Benefit	In-Network	Out-of-Network
Physician Services Non-Specialist/Specialist office visit	Selected Copay[2] per visit If no Copay Option selected, then selected Deductible and Co-insurance	Selected Deductible and Co-insurance
Preventive Services	$0[2]	Selected Deductible and Co-insurance
Hospital[1] Inpatient/Outpatient	Selected Deductible and Co-insurance	Selected Deductible and Co-insurance
Urgent Care	$50[2] Copay per visit if a Copay is selected If no Copay Option is selected, then selected Deductible and Co-insurance	
Emergency Care	$100[2] Copay per visit if a Copay is selected (Copay waived if admitted) If no Copay Option is selected, then selected Deductible and Co-insurance	
Diagnostic Lab X-ray, MRI, PET, CAT[1]	$0 Selected Deductible and Co-insurance	Selected Deductible and Co-insurance
Acupuncture, Chiropractic Biofeedback	Selected Deductible and Co-insurance; $1,500 calendar year combined maximum	Not Covered
Transplants[1]	Selected Deductible and Co-insurance	Not Covered
Dental Discount Program	See separate illustration for details. Access to lower cost dental care available from Delta Dental Patient Direct® dentists	
Vision	See separate illustration for details. Administered by Vision Service Plan Insurance Company	

Prescription Benefit Options[2] *(Does not apply toward medical deductible or out-of-pocket maximum)*

	Generic (Preferred)	Brand (Preferred)	Non-Preferred	Specialty Pharm.[1]
Option 1	$5	$35	$50	20% up to a maximum out-of-pocket of $400 per Rx and $2,500 per calendar year
Option 2	$10	$50	$75	
Option 3	$10	$50[3]	$75[3]	

[1]Benefit Certification will be required. [2]Not subject to deductible. [3]$250 pharmacy deductible (combined brand and non-preferred).

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