PRESBYTERIAN
Insurance Company, Inc.

2023 Small Group PPO Overview - All plans are offered on and off-exchange.

Bronze 1 is not Medicare Part D creditable

PPO Benefits	Platinum 1	Platinum 2	Gold 1	Gold 2	Gold 3	HDHP Gold 4*	HDHP Silver 1*	Silver 3	Silver 4	Silver 8 with TytoHome	Bronze 1
A **deductible** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x individual deductible. (in/out-of-network)	$500/$1,000	$0/$500	$1,200/$2,400	$750/$1,500	$3,500/$7,000	$3,200/$6,400	$3,200/$6,400	$2,500/$5,000	$4,000/$8,000	$4,000/$8,000	$9,100/$18.200
Coinsurance (in/out-of-network)	20% / 50%	20% / 50%	20% / 50%	20%/50%	20%/50%	0%/0%	20% / 50%	30% / 50%	30% / 50%	20% / 50%	0% / 0%
What do I pay for covered benefits?	**Copayment-Benefits with a copayment ($) 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.**										
The following benefits are what you pay (in-network only).											
Preventive Care	You pay $0. Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy, and routine immunizations.										
Primary Care Provider Visit	$10	$10	$30	$40	$30	No Charge After Deductible	20%	$40	$30	$50, $0 TytoHome	$40
Urgent Care	$10	$10	$30	$40	$30	No Charge After Deductible	20%	$40	$30	$50, $0 TytoHome	$40
Telehealth/Video Visit	$0	$0	$0	$0	$0	No Charge After Deductible	No Charge After Deductible	$0	$0	$0	$0
Specialist Visit	$30	$25	$90	$90	$90	No Charge After Deductible	20%	$90	$90	$100, $0 TytoHome	No Charge After Deductible
Mental Health	$0	$0	$0	$0	$0	No Charge After Deductible	No Charge After Deductible	$0	$0	$0	$0
Lab	$0	$0	$0	$0	$0	No Charge After Deductible	20%	$50	$50	$50	No Charge After Deductible
X-Ray	$0	$0	$0	$0	$0	No Charge After Deductible	20%	$110	$110	$100	No Charge After Deductible
Imaging CT/PET/MRI	$250	$100	$500	$500	$750	No Charge After Deductible	20%	$750	$500	$500	No Charge After Deductible
Emergency Room Plans with copay ($) all services are included	$250	$100	$500	$500	$500	No Charge After Deductible	20%	$1,000	$1,000	$1,000	No Charge After Deductible
Ambulance (air)	20%	20%	20%	20%	20%	No Charge After Deductible	20%	30%	30%	20%	No Charge After Deductible
Ambulance (ground)	$100	$100	$250	$250	$250	No Charge After Deductible	20%	$250	$250	$250	No Charge After Deductible
Hospital Inpatient and Outpatient	20%	$250 per day, $750 max/$200	20%	20%	20%	No Charge After Deductible	20%	30%	30%	20%	50% Not Subject to Deductible/0%
Chiropractic and Acupuncture Limited to 20 visits each	$10	$10	$30	$40	$30	No Charge After Deductible	20%	$40	$30	$50	$40
Rehabilitation Therapy Physical, Occupational and Speech	$10	$10	$30	$40	$30	No Charge After Deductible	20%	$40	$30	$50	$40
Prescription Drugs per 30-day supply											
Tier 1: Preferred Generic	$0	$0	$0	$0	$0	No Charge After Deductible	No Charge After Deductible	$0	$0	$0	$0
Tier 2: Non-Preferred Generic	$10	$5	$20	$15	$20	No Charge After Deductible	20%	$25	$25	$25	$25
Tier 3: Preferred Brand	$20	$10	$50	$75	$75	No Charge After Deductible	20%	$130	$130	$130	No Charge After Deductible
Tier 4: Non-Preferred Brand	$75	$50	$125	$150	$150	No Charge After Deductible	20%	$150	$150	$150	No Charge After Deductible
Tier 5: Specialty Pharmaceuticals	20%	$250	20%	20%	20%	No Charge After Deductible	20%	30%	30%	20%	No Charge After Deductible
Out-of-Pocket Maximum includes the deductible, copayments, coinsurance, and prescription drug costs that you pay. (in/out-of-network)											
The family out-of-pocket maximum is 2x the individual out-of-pocket maximum. (in/out-of-network)	$3,200/$6,400	$3,000 / $6,000	$9,100/$18,200	$9,100/$18,200	$5,500/$11,000	$3,200/$6,400	$7,000 / $14,000	$9,100/$18,200	$9,100/$18,200	$9,100/$18,200	$9,100/$18,200
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	Presbyterian Health Plan is pleased to provide you with vision coverage options for your entire family. See flyer for details. (Administered by Davis Vision.)										
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.

Medicare Part D creditable plans indicate the prescription drug coverage offered by the employer is at least as good as the Medicare drug benefit. The beneficiary may stay in that plan and choose not to enroll in the Medicare Drug Plan without risk of financial penalty.

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services - https://www.phs.org/Pages/nondiscrimination.aspx

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