

Presbyterian Medical Benefits at a Glance				Independent Option This option allows you to use ANY provider network of your choice.	
Plan Benefits/Coverage	Active Option	Family Option		In-Network	Out-of-Network ¹
		Adult	Child (Dependent to Age 26)		
Individual Deductible	\$175 Individual \$350 Family	\$175 Individual \$350 Family		\$175 Individual \$350 Family	\$500 Individual \$1,000 Family
Annual-Out-of-Pocket Maximum (includes medical through PHP and pharmacy through Optum Rx)	\$6,350 Individual \$12,700 Family max	\$6,350 Individual \$12,700 Family max		\$6,350 Individual \$12,700 Family max	\$12,700 Individual \$25,400 Family max
Preventive Care ²	\$0	\$0	\$0	\$0	40%
Primary Care Provider Visit Telehealth visits will have the same cost share as the office visits.	\$35	\$40	\$10	\$40	40%
Video visits through the myPRES portal with a nationwide network of providers	\$0	\$0	\$0	\$0	\$0
Specialist Provider Visit	\$50	\$55	\$40	\$55	40%
Behavioral Health Provider Visit ⁶	\$0	\$0	\$0	\$0	40%
Chiropractic and Acupuncture Each limited to 20 visits per plan year	\$50	\$55	\$40	\$55	40%
Outpatient Speech, Physical, and Occupational Therapy Up to 24 visits per year combined	\$35	\$40	\$10	\$40	40%
Colorectal Screening	\$0	\$0	\$0	\$0	40%
Diagnostic Lab, X-Ray, EKG	\$0	\$0	\$0	\$0	40%
Imaging and Scanning ^{3,4}	\$125 PET/MRI \$75 CT scan	\$200 PET/MRI \$125 CT scan	\$100 PET/MRI \$75 CT scan	\$125 PET/MRI \$75 CT scan	40%
Urgent Care ⁴	\$50 in network \$50 out network	\$50 in network \$50 out network	\$10 in network \$10 out network	\$50	\$50
Emergency Room Visit ⁴	\$200 includes all services and waived if admitted				
Emergency Medical Transportation ⁴	\$50 ground/\$100 air				
Hospital Inpatient Stay ^{3,4} Hospice/Skilled Nursing Care ^{3,4}	\$500 per admission	\$500 per admission	\$350 per admission	\$500 per admission	40%
Outpatient Surgery ^{3,4}	20% up to \$500 per visit	20% up to \$500 per visit	20% up to \$200 per visit	20% up to \$500 per visit	40%
Maternity Care – Prenatal and Postnatal	\$35 per visit up to \$200	\$40 per visit up to \$300 ⁵		\$40 per visit up to \$300 ⁵	40%
Infertility Services ⁴	50%				Not Covered
Transgender Services ^{4,5}	Coverage of medically necessary services for individuals who meet the qualifying diagnosis include certain surgical procedures, hormonal therapy and behavioral health support. Requires Prior Authorization.				
Durable Medical Equipment ^{3,4}	50%				
Home Healthcare	\$0				40%
Unique Service Reimbursement	\$150 per year	\$0 per year		\$250 per year	

Prescription Drugs - Your prescription benefits are administered by OptumRX. You can contact OptumRX by calling 1-800-372-8563.

¹ Out-of-network benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges. Deductible applies to all out-of-network services.

² For a complete list of preventive services, visit www.healthcare.gov/what-are-my-preventive-care-benefits.

³ Prior authorization required.

⁴ Subject to annual deductible.

⁵ Per pregnancy. Delivery subject to inpatient cost sharing and prior authorization.

⁶ In-network Behavioral Health Services are covered at \$0 copay when the diagnosis is the primary or secondary diagnosis on the claim. Effective 7/1/2023