

CUSTOM CARE – HMO ¹	Custom Care \$15		Custom Care \$20		Custom Care \$30		Custom Care \$40	
Product Identification Number(s):	HHH20004		HHH20005		HHH20007		HHH20012	
In- or Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0	Not Covered	\$0	Not Covered	\$0	Not Covered	\$0	Not Covered
Co-Insurance	0%	Not Covered	0%	Not Covered	0%	Not Covered	0%	Not Covered
Out-of-Pocket Maximum	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered
Preventive Care	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered
Primary Care Provider Visit	\$15 Per Visit	Not Covered	\$20 Per Visit	Not Covered	\$30 Per Visit	Not Covered	\$40 Per Visit	Not Covered
Video Visit	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Specialist Visit	\$25 Per Visit	Not Covered	\$30 Per Visit	Not Covered	\$40 Per Visit	Not Covered	\$50 Per Visit	Not Covered
Diagnostic Lab	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Diagnostic X-Ray	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Imaging CT/PET/MRI	10% Coinsurance to Max. of \$150 Per Test	Not Covered	15% Coinsurance to Max. of \$250 Per Test	Not Covered	15% Coinsurance to Max. of \$300 Per Test	Not Covered	20% Coinsurance to Max. of \$400 Per Test	Not Covered
Urgent Care	\$25 Per Visit	\$25 Per Visit	\$30 Per Visit	\$30 Per Visit	\$40 Per Visit	\$40 Per Visit	\$50 Per Visit	\$50 Per Visit
Emergency Room Plans with (\$) copay includes all services	\$100 Per Visit	\$100 Per Visit	\$100 Per Visit	\$100 Per Visit	\$150 Per Visit	\$150 Per Visit	\$150 Per Visit	\$150 Per Visit
Inpatient Hospital	\$250 Per Admission	Not Covered	\$500 Per Admission	Not Covered	\$1,000 Per Admission	Not Covered	\$1,500 Per Admission	Not Covered
Outpatient Hospital	10% Coinsurance to Max. of \$150 Per Visit	Not Covered	15% Coinsurance to Max. of \$250 Per Visit	Not Covered	15% Coinsurance to Max. of \$300 Per Visit	Not Covered	20% Coinsurance to Max. of \$400 Per Visit	Not Covered
Durable Medical Equipment	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered
Retail Pharmacy Benefits Available	7/25/45 10/20/40 10/30/50 10/35/55 15/35/55	Not Covered	7/25/45 10/20/40 10/30/50 10/35/55 15/35/55	Not Covered	7/25/45 10/20/40 10/30/50 10/35/55 15/35/55	Not Covered	7/25/45 10/20/40 10/30/50 10/35/55 15/35/55	Not Covered
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable		Creditable	

¹ 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.

² The Presbyterian Health Plan pays 100% for Clinical Preventive Health Services as outlined in the Affordable Care Act. Services include, but are not limited to: annual physical exam, colonoscopy, and routine immunizations.