



Presbyterian Health Plan, Inc.
 Presbyterian Insurance Company, Inc.

| PREFERRED CARE PLUS-PPO ¹ | Preferred Care Plus \$250/\$30 | | Preferred Care Plus \$500/\$30 | | Preferred Care Plus \$1,000/\$30 | | Preferred Care Plus \$1,000/\$20 | | Preferred Care Plus \$1,500/\$30 | | Preferred Care Plus \$2,000/\$30 | | Preferred Care Plus \$3,000/\$30 | | Preferred Care Plus \$3,000/\$10 | | Preferred Care Plus \$4,000/\$30 | |
|--|---------------------------------------|--|---------------------------------------|--|---------------------------------------|--|---------------------------------------|--|---------------------------------------|--|--|---|--|---|--|---|--|---|
| Product Identification Number(s): | IIP20037 | | IIP20038 | | IIP20039 | | IIP20023 | | IIP20040 | | IIP20041 | | IIP20042 | | IIP20024 | | IIP20043 | |
| 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 | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Deductible | \$250 Individual/ \$500 Family | \$500 Individual/ \$1,000 Family | \$500 Individual/ \$1,000 Family | \$1,000 Individual/ \$2,000 Family | \$1,000 Individual/ \$2,000 Family | \$2,000 Individual/ \$4,000 Family | \$1,000 Individual/ \$2,000 Family | \$2,000 Individual/ \$4,000 Family | \$1,500 Individual/ \$3,000 Family | \$3,000 Individual/ \$6,000 Family | \$2,000 Individual/ \$4,000 Family | \$4,000 Individual/ \$8,000 Family | \$3,000 Individual/ \$6,000 Family | \$6,000 Individual/ \$12,000 Family | \$3,000 Individual/ \$6,000 Family | \$6,000 Individual/ \$12,000 Family | \$4,000 Individual/ \$8,000 Family | \$8,000 Individual/ \$16,000 Family |
| Co-Insurance | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible |
| Out-of-Pocket Maximum | \$3,500 Individual/ \$7,000 Family | \$7,000 Individual/ \$14,000 Family | \$3,500 Individual/ \$7,000 Family | \$7,000 Individual/ \$14,000 Family | \$4,000 Individual/ \$8,000 Family | \$8,000 Individual/ \$16,000 Family | \$3,600 Individual/ \$7,200 Family | \$7,200 Individual/ \$14,400 Family | \$4,500 Individual/ \$9,000 Family | \$9,000 Individual/ \$18,000 Family | \$5,000 Individual/ \$10,000 Family | \$10,000 Individual/ \$20,000 Family | \$6,500 Individual/ \$13,000 Family | \$13,000 Individual/ \$26,000 Family | \$6,850 Individual/ \$13,700 Family | \$13,700 Individual/ \$27,400 Family | \$6,500 Individual/ \$13,000 Family | \$13,000 Individual/ \$26,000 Family |
| Preventive Care | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible |
| Primary Care Provider Visit | \$30 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible | \$20 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible | \$10 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible |
| Specialist Visit | \$40 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible | \$50 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible | \$50 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible |
| Diagnostic Lab | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible |
| Diagnostic X-Ray | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible |
| Imaging CT/PET/MRI | \$200 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible | \$250 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible | \$250 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible |
| Urgent Care | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$50 Per Visit | \$50 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$40 Per Visit | \$50 Per Visit | \$50 Per Visit | \$40 Per Visit | \$40 Per Visit |
| Emergency Room (plans with \$ copay includes all services) | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$150 Per Visit | \$150 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$300 Per Visit | \$250 Per Visit | \$250 Per Visit | \$300 Per Visit | \$300 Per Visit |
| Inpatient Hospital | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible |
| Outpatient Hospital | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible |
| Durable Medical Equipment | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible |
| Retail Pharmacy Benefits Available | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 |
| Is this plan Medicare Part D Creditable? | Creditable | | Creditable | | Creditable | | Creditable | | Creditable | | Creditable | | Creditable | | Creditable | | Creditable | |

Prescription Drug Benefit Packages - See separate benefit grid for Prescription Drug Benefit Options



Presbyterian Health Plan, Inc.
 Presbyterian Insurance Company, Inc.

| PREFERRED CARE PLUS-PPO ¹ | Preferred Care Plus \$5,000/\$30 | | Preferred Care Plus \$5,000/\$5 | | Preferred Care Plus \$6,000/\$30 | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|
| Product Identification Number(s): | IIP20044 | | IIP20025 | | IIP20149 IIP20161 IIP20162 | | | | | | | | | | | | |
| In- or Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | | | | | | | | | | | |
| Deductible | \$5,000 Individual/ \$10,000 Family | \$10,000 Individual/ \$20,000 Family | \$5,000 Individual/ \$10,000 Family | \$10,000 Individual/ \$20,000 Family | \$6,000 Individual/ \$12,000 Family | \$12,000 Individual/ \$24,000 Family | | | | | | | | | | | |
| Co-Insurance | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | | | | | | | | | | | |
| Out-of-Pocket Maximum | \$7,000 Individual/ \$14,000 Family | \$14,000 Individual/ \$28,000 Family | \$6,850 Individual/ \$13,700 Family | \$13,700 Individual/ \$27,400 Family | \$7,500 Individual/ \$15,000 Family | \$15,000 Individual/ \$30,000 Family | | | | | | | | | | | |
| Preventive Care | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | No Charge ² | 50% After Deductible | | | | | | | | | | | |
| Primary Care Provider Visit | \$30 Per Visit | 50% After Deductible | \$5 Per Visit | 50% After Deductible | \$30 Per Visit | 50% After Deductible | | | | | | | | | | | |
| Specialist Visit | \$40 Per Visit | 50% After Deductible | \$50 Per Visit | 50% After Deductible | \$40 Per Visit | 50% After Deductible | | | | | | | | | | | |
| Diagnostic Lab | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | | | | | | | | | | | |
| Diagnostic X-Ray | No Charge | 50% After Deductible | No Charge | 50% After Deductible | No Charge | 50% After Deductible | | | | | | | | | | | |
| Imaging CT/PET/MRI | \$200 Per Test | 50% After Deductible | \$250 Per Test | 50% After Deductible | \$200 Per Test | 50% After Deductible | | | | | | | | | | | |
| Urgent Care | \$40 Per Visit | \$40 Per Visit | \$50 Per Visit | \$50 Per Visit | \$40 Per Visit | \$40 Per Visit | | | | | | | | | | | |
| Emergency Room (plans with \$ copay includes all services) | \$300 Per Visit | \$300 Per Visit | \$250 Per Visit | \$250 Per Visit | \$300 Per Visit | \$300 Per Visit | | | | | | | | | | | |
| Inpatient Hospital | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | | | | | | | | | | | |
| Outpatient Hospital | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | | | | | | | | | | | |
| Durable Medical Equipment | 30% After Deductible | 50% After Deductible | 20% After Deductible | 50% After Deductible | 30% After Deductible | 50% After Deductible | | | | | | | | | | | |
| Retail Pharmacy Benefits Available | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | 10/20/40 10/30/50 10/35/55 | | | | | | | | | | | |
| Is this plan Medicare Part D Creditable? | Creditable | | Creditable | | Creditable | | | | | | | | | | | | |

Prescription Drug Benefit Packages - See separate benefit grid for Prescription Drug Benefit Options

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. For information on Presbyterian Health Plan's Nondiscrimination Notice, go to <https://www.phs.org/nondiscrimination>.