



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

LEVEL FUNDED PREFERRED CARE- PPO ¹	Preferred Care \$250/20%		Preferred Care \$500/20%		Preferred Care \$500/30%		Preferred Care \$750/20%		Preferred Care \$1000/20%		Preferred Care \$1000/30%		Preferred Care \$1500/20%		Preferred Care \$1500/30%		Preferred Care \$2000/20%	
Product Identification Number(s):	HLP20000		HLP20009		HLP20007		HLP20002		HLP20001		HLP20011		HLP20010				HLP20008	
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/ \$1000 Family	\$500 Individual/ \$1000 Family	\$1000 Individual/ \$2000 Family	\$500 Individual/ \$1000 Family	\$1000 Individual/ \$2000 Family	\$750 Individual/ \$1500 Family	\$1500 Individual/ \$3000 Family	\$1000 Individual/ \$2000 Family	\$2000 Individual/ \$4000 Family	\$1000 Individual/ \$2000 Family	\$2000 Individual/ \$4000 Family	\$1500 Individual/ \$3000 Family	\$3000 Individual/ \$6000 Family	\$1500 Individual/ \$3000 Family	\$3000 Individual/ \$6000 Family	\$2000 Individual/ \$4000 Family	\$4000 Individual/ \$8000 Family
Co-Insurance	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Out-of-Pocket Maximum	\$3000 Individual/ \$6000 Family	\$6000 Individual/ \$12000 Family	\$3000 Individual/ \$6000 Family	\$6000 Individual/ \$12000 Family	\$5500 Individual/ \$11000 Family	\$11000 Individual/ \$22000 Family	\$3250 Individual/ \$6500 Family	\$6500 Individual/ \$13000 Family	\$3500 Individual/ \$7000 Family	\$7000 Individual/ \$14000 Family	\$6000 Individual/ \$12000 Family	\$12000 Individual/ \$24000 Family	\$4000 Individual/ \$8000 Family	\$8000 Individual/ \$16000 Family	\$6350 Individual/ \$12700 Family	\$12700 Individual/ \$25400 Family	\$4500 Individual/ \$9000 Family	\$9000 Individual/ \$18000 Family
Preventive Care	No Charge ²	40% After Deductible	No Charge ²	40% After Deductible	No Charge ²	50% After Deductible	No Charge ²	40% After Deductible	No Charge ²	40% After Deductible	No Charge ²	50% After Deductible	No Charge ²	40% After Deductible	No Charge ²	50% After Deductible	No Charge ²	40% After Deductible
Primary Care Provider Visit	\$20 Per Visit	40% After Deductible	\$20 Per Visit	40% After Deductible	\$30 Per Visit	50% After Deductible	\$20 Per Visit	40% After Deductible	\$20 Per Visit	40% After Deductible	\$30 Per Visit	50% After Deductible	\$20 Per Visit	40% After Deductible	\$30 Per Visit	50% After Deductible	\$20 Per Visit	40% After Deductible
Specialist Visit	\$30 Per Visit	40% After Deductible	\$30 Per Visit	40% After Deductible	\$40 Per Visit	50% After Deductible	\$30 Per Visit	40% After Deductible	\$30 Per Visit	40% After Deductible	\$40 Per Visit	50% After Deductible	\$30 Per Visit	40% After Deductible	\$40 Per Visit	50% After Deductible	\$30 Per Visit	40% After Deductible
Diagnostic Lab	No Charge	40% After Deductible	No Charge	40% After Deductible	No Charge	50% After Deductible	No Charge	40% After Deductible	No Charge	40% After Deductible	No Charge	50% After Deductible	No Charge	40% After Deductible	No Charge	50% After Deductible	No Charge	40% After Deductible
Diagnostic X-Ray	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Imaging CT/PET/MRI	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Urgent Care	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$40 Per Visit	\$40 Per Visit	\$30 Per Visit	\$30 Per Visit	\$40 Per Visit	\$40 Per Visit	\$30 Per Visit	\$30 Per Visit
Emergency Room (plans with \$ copay includes all services)	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible	20% After Deductible	20% After Deductible
Inpatient Hospital	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Outpatient Hospital	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Durable Medical Equipment	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible
Retail Pharmacy Benefits Available	10/20/40 10/35/55	10/20/40 10/35/55	10/20/40 10/35/55	10/20/40 10/35/55	15/35/55	15/35/55	10/20/40 10/30/50 10/35/55	10/20/40 10/30/50 10/35/55	10/35/55	10/35/55	10/20/40 10/35/55	10/20/40 10/35/55	10/20/40 10/35/55 15/35/55	10/20/40 10/35/55 15/35/55	10/20/40 10/35/55	10/20/40 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.

LEVEL FUNDED PREFERRED CARE- PPO ¹	Preferred Care \$2000/30%		Preferred Care \$2500/20%		Preferred Care \$3000/20%		Preferred Care \$3000/30%		Preferred Care \$4000/20%		Preferred Care \$4000/30%		Preferred Care \$5000/20%		Preferred Care \$5000/40%		Preferred Care \$6000/50%	
Product Identification Number(s):	HLP20004		HLP20012		HLP20029		HLP20099				HLP20049				HLP20028		HLP20098	
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	\$2000 Individual/ \$4000 Family	\$4000 Individual/ \$8000 Family	\$2500 Individual/ \$5000 Family	\$5000 Individual/ \$10000 Family	\$3000 Individual/ \$6000 Family	\$6000 Individual/ \$12000 Family	\$3000 Individual/ \$6000 Family	\$6000 Individual/ \$12000 Family	\$4000 Individual/ \$8000 Family	\$8000 Individual/ \$16000 Family	\$4000 Individual/ \$8000 Family	\$8000 Individual/ \$16000 Family	\$5000 Individual/ \$10000 Family	\$10000 Individual/ \$20000 Family	\$5000 Individual/ \$10000 Family	\$10000 Individual/ \$20000 Family	\$6000 Individual/ \$12000 Family	\$12000 Individual/ \$24000 Family
Co-Insurance	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Out-of-Pocket Maximum	\$6350 Individual/ \$12700 Family	\$12700 Individual/ \$25400 Family	\$5000 Individual/ \$10000 Family	\$10000 Individual/ \$20000 Family	\$6500 Individual/ \$13000 Family	\$13000 Individual/ \$26000 Family	\$6350 Individual/ \$12700 Family	\$12700 Individual/ \$25400 Family	\$6500 Individual/ \$13000 Family	\$13000 Individual/ \$26000 Family	\$6350 Individual/ \$12700 Family	\$12700 Individual/ \$25400 Family	\$7000 Individual/ \$14000 Family	\$14000 Individual/ \$28000 Family	\$7000 Individual/ \$14000 Family	\$14000 Individual/ \$28000 Family	\$7500 Individual/ \$15000 Family	\$15000 Individual/ \$30000 Family
Preventive Care	No Charge ²	50% After Deductible	No Charge ²	40% 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	\$20 Per Visit	40% After Deductible	\$20 Per Visit	50% After Deductible	\$30 Per Visit	50% After Deductible	\$20 Per Visit	50% After Deductible	\$30 Per Visit	50% After Deductible	\$20 Per Visit	50% After Deductible	\$20 Per Visit	50% After Deductible	\$20 Per Visit	50% After Deductible
Specialist Visit	\$40 Per Visit	50% After Deductible	\$30 Per Visit	40% After Deductible	\$30 Per Visit	50% After Deductible	\$40 Per Visit	50% After Deductible	\$30 Per Visit	50% After Deductible	\$40 Per Visit	50% After Deductible	\$30 Per Visit	50% After Deductible	\$50 Per Visit	50% After Deductible	\$50 Per Visit	50% After Deductible
Diagnostic Lab	No Charge	50% After Deductible	No Charge	40% 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	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Imaging CT/PET/MRI	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Urgent Care	\$40 Per Visit	\$40 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$30 Per Visit	\$40 Per Visit	\$40 Per Visit	\$30 Per Visit	\$30 Per Visit	\$40 Per Visit	\$40 Per Visit	\$30 Per Visit	\$30 Per Visit	\$75 Per Visit	\$75 Per Visit	\$75 Per Visit	\$75 Per Visit
Emergency Room (plans with \$ copay includes all services)	30% After Deductible	30% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible	20% After Deductible	20% After Deductible	40% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible
Inpatient Hospital	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Outpatient Hospital	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Durable Medical Equipment	30% After Deductible	50% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	20% After Deductible	50% After Deductible	40% After Deductible	50% After Deductible	50% 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

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>.