PRESBYTERIAN

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

LEVEL FUNDED PREFERRED CARE PLUS-PPO[1]	Preferred Care Plus $250/$30		Preferred Care Plus $500/$30		Preferred Care Plus $1000/$30		Preferred Care Plus $1000/$20		Preferred Care Plus $1500/$30		Preferred Care Plus $2000/$30		Preferred Care Plus $3000/$30		Preferred Care Plus $3000/$10		Preferred Care Plus $4000/$30	
Product Identification Number(s):	HLP20101		HLP20021		HLP20027		HLP20044		HLP20020		HLP20022		HLP20024				HLP20033	
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/ I$1000 Family	$1000 Individual/ $2000 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	$2000 Individual/ $4000 Family	$4000 Individual/ $8000 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
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	$3500 Individual/ $7000 Family	$7000 Individual/ $14000 Family	$3500 Individual/ $7000 Family	$7000 Individual/ $14000 Family	$4000 Individual/ $8000 Family	$8000 Individual/ $16000 Family	$3600 Individual/ $7200 Family	$7200 Individual/ $14400 Family	$4500 Individual/ $9000 Family	$9000 Individual/ $18000 Family	$5000 Individual/ $10000 Family	$10000 Individual/ $20000 Family	$6500 Individual/ $13000 Family	$13000 Individual/ $26000 Family	$6850 Individual/ $13700 Family	$13700 Individual/ $27400 Family	$6500 Individual/ $13000 Family	$13000 Individual/ $26000 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

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

LEVEL FUNDED PREFERRED CARE PLUS-PPO[1]	Preferred Care Plus $5000/$30		Preferred Care Plus $5000/$5		Preferred Care Plus $6000/$30													
Product Identification Number(s):	HLP20023																	
In- or Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network												
Deductible	$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	50% After Deductible	30% After Deductible	50% After Deductible												
Out-of-Pocket Maximum	$7000 Individual/ $14000 Family	$14000 Individual/ $28000 Family	$6850 Individual/ $13700 Family	$13700 Individual/ $27400 Family	$7500 Individual/ $15000 Family	$15000 Individual/ $30000 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.