

| 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/ \$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

| 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>.