PRESBYTERIAN

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 Individua/ $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
Coinsurance	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 30-day supply																		
Tier 1 – Generic	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay
Tier 2 – Preferred Brand	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay
Tier 3 – Non-Preferred	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay	$55 Copay
Tier 4 – Self-Administered Specialty	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered
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																		

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PREFERRED CARE PLUS-PPO Error! Bookmark not defined.	Preferred Care Plus $5,000/$30		Preferred Care Plus $6,000/$30		Preferred Care Plus $6,000/$30		Preferred Care Plus $6,000/$30											
Product Identification Number(s):	IIP20044		IIP20149		IIP20161		IIP20162											
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	$5,000 Individual/ $10,000 Family	$10,000 Individual/ $20,000 Family	$6,000 Individual/ $12,000 Family	$12,000 Individual/ $24,000 Family	$6,000 Individual/ $12,000 Family	$12,000 Individual/ $24,000 Family	$6,000 Individual/ $12,000 Family	$12,000 Individual/ $24,000 Family										
Coinsurance	30% After Deductible	50% After Deductible	30% After Deductible	50% After Deductible	30% 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	$7,500 Individual/ $15,000 Family	$15,000 Individual/ $30,000 Family	$7,500 Individual/ $15,000 Family	$15,000 Individual/ $30,000 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	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	$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	$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										
Diagnostic X-Ray	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	$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	$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	$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	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	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	30% After Deductible	50% After Deductible										
Retail Pharmacy 30-day supply																		
Tier 1 – Generic	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay										
Tier 2 – Preferred Brand	$35 Copay	$35 Copay	$20 Copay	$20 Copay	$30 Copay	$30 Copay	$35 Copay	$35 Copay										
Tier 3 – Non-Preferred	$55 Copay	$55 Copay	$40 Copay	$40 Copay	$50 Copay	$50 Copay	$55 Copay	$55 Copay										
Tier 4 – Self-Administered Specialty	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered										
Is this plan Medicare Part D 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.