

PREFERRED CARE- PPO¹	Preferred Care \$250/20%		Preferred Care \$500/20%		Preferred Care \$500/30%		Preferred Care \$750/20%		Preferred Care \$1,000/20%		Preferred Care \$1,000/30%		Preferred Care \$1,500/20%		Preferred Care \$1,500/30%		Preferred Care \$2,000/20%	
Product Identification Number(s):	IIP20011		IIP20002		IIP20007		IIP20003		IIP20004		IIP20008		IIP20005		IIP20009		IIP20006	
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	\$500 Individual/ \$1,000 Family	\$1,000 Individual/ \$2,000 Family	\$750 Individual/ \$1,500 Family	\$1,500 Individual/ \$3,000 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	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual/ \$8,000 Family
Coinsurance	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	\$3,000 Individual/ \$6,000 Family	\$6,000 Individual/ \$12,000 Family	\$3,000 Individual/ \$6,000 Family	\$6,000 Individual/ \$12,000 Family	\$5,500 Individual/ \$11,000 Family	\$11,000 Individual/ \$22,000 Family	\$3,250 Individual/ \$6,500 Family	\$6,500 Individual/ \$13,000 Family	\$3,500 Individual/ \$7,000 Family	\$7,000 Individual/ \$14,000 Family	\$6,000 Individual/ \$12,000 Family	\$12,000 Individual/ \$24,000 Family	\$4,000 Individual/ \$8,000 Family	\$8,000 Individual/ \$16,000 Family	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	\$4,500 Individual/ \$9,000 Family	\$9,000 Individual/ \$18,000 Family
Preventive Care	No Charge²	40% After Deductible	No Charge²	40% After Deductible	No Charge²	50% After Deductible	No Charge²	40% After Deductible	No Charge²	40% After Deductible	No Charge²	50% After Deductible	No Charge²	40% After Deductible	No Charge²	50% After Deductible	No Charge²	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 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																		



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

PREFERRED CARE- PPO <sup>1</sup>	Preferred Care \$2,000/30%		Preferred Care \$2,500/20%		Preferred Care \$3,000/20%		Preferred Care \$3,000/30%		Preferred Care \$4,000/20%		Preferred Care \$4,000/30%		Preferred Care \$5,000/20%		Preferred Care \$5,000/40%		Preferred Care \$6,000/50%	
Product Identification Number(s):	IIP20010		IIP20013		IIP20045		IIP20034		IIP20046		IIP20035		IIP20047		IIP20036		IIP20063	
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	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual/ \$8,000 Family	\$2,500 Individual/ \$5,000 Family	\$5,000 Individual/ \$10,000 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	\$4,000 Individual/ \$8,000 Family	\$8,000 Individual/ \$16,000 Family	\$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
Coinsurance	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	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 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	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	\$6,500 Individual/ \$13,000 Family	\$13,000 Individual/ \$26,000 Family	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	\$7,000 Individual/ \$14,000 Family	\$14,000 Individual/ \$28,000 Family	\$7,000 Individual/ \$14,000 Family	\$14,000 Individual/ \$28,000 Family	\$7,500 Individual/ \$15,000 Family	\$15,000 Individual/ \$30,000 Family
Preventive Care	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	40% After Deductible	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	50% After Deductible	No Charge <sup>2</sup>	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 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																		
<sup>1</sup> 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 <a href="http://www.phs.org/formsanddocuments">www.phs.org/formsanddocuments</a> . <sup>2</sup> 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 <a href="https://www.phs.org/nondiscrimination">https://www.phs.org/nondiscrimination</a> .																		