PRESBYTERIAN

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

PREFERRED CARE- PPO[1]	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	$,2000 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 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 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

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

PREFERRED CARE- PPO[1]Error! Bookmark not defined.	Preferred Care $2,000/30%		Preferred Care $2,500/20%		Preferred Care $3,000/20%		Preferred Care $3,000/30%		Preferred Care $,4000/20%		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[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 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																		

[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.