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 | $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 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 | 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 | | | | | | | | | | | | | | | | | | |

[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 Group 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**.

PRESBYTERIAN
Insurance Company, Inc.

| PREFERRED CARE – PPO[1] | 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[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 | 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 Group 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.

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