PRESBYTERIAN
Insurance Company, Inc.

LEVEL FUNDED 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):	HLP20000		HLP20009		HLP20007		HLP20002		HLP20001		HLP20011		HLP20010		N/A		HLP20008	
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**.

MPC042650

PRESBYTERIAN
Insurance Company, Inc.

LEVEL FUNDED 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):	HLP20004		HLP20012		HLP20029		HLP20099		N/A		HLP20049		N/A		HLP20028		HLP20098	
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																		

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