PRESBYTERIAN
Insurance Company, Inc.

LEVEL FUNDED PREFERRED CARE PLUS – PPO[1]	Level Funded Preferred Care Plus - PPO[1] $250 / $30		Level Funded Preferred Care Plus - PPO[1] $500 / $30		Level Funded Preferred Care Plus - PPO[1] $1,000 / $30		Level Funded Preferred Care Plus - PPO[1] $1,000 / $20	
Product Identification Number(s):	HLP20101		HLP20021		HLP20027		HLP20044	
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	$250 Individual/ $500 Family	$500 Individual/ $1,000 Family	$500 Individual/ $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
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
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
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	$20 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
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	$250 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
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
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
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
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
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	$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
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**.

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PRESBYTERIAN
Insurance Company, Inc.

LEVEL FUNDED PREFERRED CARE PLUS – PPO[1]	Level Funded Preferred Care Plus - PPO[1] $1,500 / $30		Level Funded Preferred Care Plus - PPO[1] $2,000 / $30		Level Funded Preferred Care Plus - PPO[1] $3,000 / $30		Level Funded Preferred Care Plus - PPO[1] $4,000 / $30	
Product Identification Number(s):	HLP20020		HLP20022		HLP20024		HLP20033	
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	$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	$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	30% After Deductible	50% After Deductible
Out-of-Pocket Maximum	$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	$6,500 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
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	$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
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**.

PRESBYTERIAN
Insurance Company, Inc.

LEVEL FUNDED PREFERRED CARE PLUS – PPO[1]	Level Funded Preferred Care Plus - PPO[1] $5,000 / $30		Level Funded Preferred Care Plus - PPO[1] $6,000 / $30		Level Funded Preferred Care Plus - PPO[1] $6,000 / $30		Level Funded Preferred Care Plus - PPO[1] $6,000 / $30	
Product Identification Number(s):	HLP20023		N/A		N/A		HLP20111	
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**.
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