## A PRESBYTERIAN

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

9250   5500   5500   5100   5200   5100   5200   500   6410   500   6410   5200   500   6410   500		Preferred Care   \$1,000 / \$20		Preferred Care Plus \$1,000 / \$30		Preferre \$500	d Care Plus ) / \$30		PREFERRED CARE PLUS – PPO <sup>1</sup>	
Beductible   S200   S900	IIP20023 IIP20040 IIP20041		IIP20039		IIP20038		IIP20037		Product Identification Number(s):	
DeductibleIndividual<	k Out-of-Network In-Network Out-of-Network In-Network Out-of-Network	twork In-Net	Out-of-Net	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In- or Out-of-Network	
Co-InsuranceDeductible <td>/ Individual/ Individual/ Individual/ Individual/</td> <td>al/ Individ</td> <td>Individua</td> <td>Individual/</td> <td>Individual/</td> <td>Individual/</td> <td>Individual/</td> <td>Individual/</td> <td>Deductible</td>	/ Individual/ Individual/ Individual/ Individual/	al/ Individ	Individua	Individual/	Individual/	Individual/	Individual/	Individual/	Deductible	
Cut-of-Pocket MaximumIndividual/ \$7,000 FamilyIndividual/ \$14,000 FamilyIndividual/ 									Co-Insurance	
Preventive CareNo ChargeDeductibleNo ChargeDeductibleNo ChargeDeductibleNo ChargeDeductibleNo ChargeDeductibleNo ChargeDeductibleNo ChargeDeductibleNo ChargeDeductiblePer VisitDeductiblePer VisitDeductiblePer VisitDeductiblePer VisitDeductiblePer VisitDeductiblePer VisitDeductiblePer VisitDeductiblePer VisitDeductibleNo ChargeS0% AfterS30S0% AfterS0% After<	/ Individual/ Individual/ Individual/ Individual/ Individual/	al/ Indivic	Individua	Individual/	Individual/	Individual/	Individual/	Individual/	Out-of-Pocket Maximum	
Primary Care Provider Visit*Per Visit*DeductiblePer Visit*DeductibleNo Charge*DeductibleNo Charge*DeductibleNo Charge*DotterS0% AfterS0% AfterPer Visit*S0% AfterS0% AfterS0% AfterPer Visit*S0% AfterS0% AfterS0% AfterPer Visit*S0% AfterS0% AfterS0% AfterS0% AfterS0% AfterS0% AfterS0% AfterPer Visit*S0% AfterS0% After <td></td> <td></td> <td></td> <td>No Charge<sup>2</sup></td> <td></td> <td>No Charge<sup>2</sup></td> <td></td> <td>No Charge</td> <td>Preventive Care</td>				No Charge <sup>2</sup>		No Charge <sup>2</sup>		No Charge	Preventive Care	
Video VisitNo ChargeDeductibleNo Charge'DeductibleNo Charge'S0% After\$40S0% AfterPer Visit'DeductiblePer Visit'DeductiblePer Visit'DeductibleNo Charge'DeductibleNo Charge'S0% AfterPer Visit'DeductibleNo Charge'S0% AfterS0% AfterDeductibleNo Charge'S0% AfterS0% AfterDeductibleNo Charge'S0% AfterS0% AfterDeductibleNo Charge'S0% AfterS0% AfterDeductibleNo Charge'S0% AfterDeductibleNo Charge'S0% AfterS0% AfterDeductibleNo Charge'S0% AfterDeductibleNo Charge'S0% AfterDeductibleNo Charge'S0% AfterDeductibleNo Charge'S0% AfterDeductibleNo Charge'S0% AfterDeductibleNo Charge'S0% AfterNo Charge'S0% AfterNo Charge'S0% AfterNo Charge'S0% AfterNo Charge'S0% AfterNo Charge'S0% AfterNo Charge'S0% AfterS0% AfterNo Charge'S0% AfterNo Charge'S0% AfterS0%									Primary Care Provider Visit	
Specialist VisitPer Visit³DeductiblePer Visit³Per Visit³				No Charge <sup>3</sup>		No Charge <sup>3</sup>		No Charge	Video Visit	
Diagnostic LabNo Charge*DeductibleNo Charge*Deductible </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Specialist Visit</td>									Specialist Visit	
Diagnostic X-RayNo Charge*DeductibleNo Charge*DeductibleNo Charge*DeductibleNo Charge*DeductibleNo Charge*DeductibleNo Charge*DeductibleDeductibleNo Charge*DeductibleDeductibleDeductibleNo Charge*DeductibleDeductibleDeductibleDeductibleDeductibleNo Charge*DeductibleDeductibleDeductibleDeductibleDeductibleDeductibleNo Charge*DeductibleDeductibleDeductibleDeductibleStopS				No Charge <sup>3</sup>		No Charge <sup>3</sup>		No Charge <sup>3</sup>	Diagnostic Lab	
Imaging C1/PE1/MRIPer Test3DeductiblePer Test3DeductibleStot4<				No Charge <sup>3</sup>		No Charge <sup>3</sup>		No Charge <sup>3</sup>	Diagnostic X-Ray	
Urgent CarePer Visit³Per Visit³									Imaging CT/PET/MRI	
(plans with \$ copay includes all services)Per Visit³Per									Urgent Care	
Inpatient Hospital30% After Deductible50% After Deductible30% After Deductible50% After Deductible30% After Deductible50% After Deductibl									<b>a</b>	
Outpatient Hospital Deductible Dedu										
									Outpatient Hospital	
									Durable Medical Equipment	
Retail Pharmacy Benefits Available   10/30/50	10/30/50 10/30/50 10/30/50 10/30/50 10/30/50	50 10/30	10/30/5	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50	Retail Pharmacy Benefits Available	
Is this plan Medicare Part D Creditable? Creditable Creditable Creditable Creditable	Creditable Creditable Creditable	Creditable Creditable				Cree	ditable	Is this plan Medicare Part D Creditable?		

<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 www.phs.org/formsanddocuments.

<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. <sup>3</sup> Deductible does not apply.

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PREFERRED CARE PLUS – PPO <sup>1</sup>		\$3,000 / \$30 \$3,000 / \$10 \$4,00		Care PlusPreferred Care Plus0 / \$30\$5,000 / \$30		Preferred Care Plus \$5,000 / \$5				
Product Identification Number(s):	IIP2			IIP20024		IIP20043		IIP20044		IIP20025
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
Deductible	\$3,000	\$6,000	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000	\$5,000	\$10,000
	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/
	\$6,000 Family	\$12,000 Family	\$6,000 Family	\$12,000 Family	\$8,000 Family	\$16,000 Family	\$10,000 Family	\$20,000 Family	\$10,000 Family	\$20,000 Family
Co-Insurance	30% After	50% After	20% After	50% After	30% After	50% After	30% After	50% After	20% After	50% After
	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Out-of-Pocket Maximum	\$6,500	\$13,000	\$6,850	\$13,700	\$6,500	\$13,000	\$7,000	\$14,000	\$6,850	\$13,700
	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/	Individual/
	\$13,000 Family	\$26,000 Family	\$13,700 Family	\$27,400 Family	\$13,000 Family	\$26,000 Family	\$14,000 Family	\$28,000 Family	\$13,700 Family	\$27,400 Family
Preventive Care	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	50% After	\$10	50% After	\$30	50% After	\$30	50% After	\$5	50% After
	Per Visit³	Deductible	Per Visit <sup>3</sup>	Deductible	Per Visit <sup>3</sup>	Deductible	Per Visit <sup>3</sup>	Deductible	Per Visit <sup>3</sup>	Deductible
Video Visit	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible
Specialist Visit	\$40	50% After	\$50	50% After	\$40	50% After	\$40	50% After	\$50	50% After
	Per Visit³	Deductible	Per Visit <sup>3</sup>	Deductible	Per Visit <sup>3</sup>	Deductible	Per Visit <sup>3</sup>	Deductible	Per Visit <sup>3</sup>	Deductible
Diagnostic Lab	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible
Diagnostic X-Ray	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible	No Charge <sup>3</sup>	50% After Deductible
Imaging CT/PET/MRI	\$200	50% After	\$250	50% After	\$200	50% After	\$200	50% After	\$250	50% After
	Per Test <sup>3</sup>	Deductible	Per Test <sup>3</sup>	Deductible	Per Test <sup>3</sup>	Deductible	Per Test <sup>3</sup>	Deductible	Per Test <sup>3</sup>	Deductible
Urgent Care	\$40	\$40	\$50	\$50	\$40	\$40	\$40	\$40	\$50	\$50
	Per Visit³	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit³	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>
Emergency Room	\$300	\$300	\$250	\$250	\$300	\$300	\$300	\$300	\$250	\$250
(plans with \$ copay includes all services)	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit³	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit³	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>	Per Visit <sup>3</sup>
Inpatient Hospital	30% After	50% After	20% After	50% After	30% After	50% After	30% After	50% After	20% After	50% After
	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Outpatient Hospital	30% After	50% After	20% After	50% After	30% After	50% After	30% After	50% After	20% After	50% After
	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Durable Medical Equipment	0% After	50% After	50% After	50% After	30% After	50% After	30% After	50% After	50% After	50% After
	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Retail Pharmacy Benefits Available	10/20/40	10/20/40	10/20/40	10/20/40	10/20/40	10/20/40	10/20/40	10/20/40	10/20/40	10/20/40
	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50	10/30/50
	10/35/55	10/35/55	10/35/55	10/35/55	10/35/55	10/35/55	10/35/55	10/35/55	10/35/55	10/35/55
Is this plan Medicare Part D Creditable?	Crec	itable	Cred	Creditable Creditable			Creditable Creditable			litable

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 www.phs.org/formsanddocuments.

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