



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

SMARTCARE – HMO ¹	Smart Care Customized \$250		Smart Care Customized \$500		Smart Care Customized \$750 / \$15		Smart Care Customized \$750 / \$30		Smart Care Customized \$1,000 / \$0		Smart Care Customized \$1,000 / \$20	
Product Identification Number(s):	HHH20013		HHH20015		HHH20035		HHH20014		HHH20031		HHH20032	
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
Deductible	\$250 Individual/ \$500 Family	Not Covered	\$500 Individual/ \$1,000 Family	Not Covered	\$750 Individual/ \$1,500 Family	Not Covered	\$750 Individual/ \$1,500 Family	Not Covered	\$1,000 Individual/ \$2,000 Family	Not Covered	\$1,000 Individual/ \$2,000 Family	Not Covered
Co-Insurance	30% After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Out-of-Pocket Maximum	\$2,750 Individual/ \$5,500 Family	Not Covered	\$3,000 Individual/ \$6,000 Family	Not Covered	\$6,850 Individual/ \$13,700 Family	Not Covered	\$3,250 Individual/ \$6,500 Family	Not Covered	\$6,600 Individual/ \$13,200 Family	Not Covered	\$3,600 Individual/ \$7,200 Family	Not Covered
Preventive Care	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered
Primary Care Provider Visit	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$15 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	No Charge ³	Not Covered	\$20 Per Visit ³	Not Covered
Video Visit	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Specialist Visit	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$25 Per Visit ³	Not Covered	\$50 Per Visit ³	Not Covered
Diagnostic Lab	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Diagnostic X-Ray	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Imaging CT/PET/MRI	\$50 Per Test ³	Not Covered	\$50 Per Test ³	Not Covered	\$250 Per Test ³	Not Covered	\$50 Per Test ³	Not Covered	\$250 Per Test ³	Not Covered	\$250 Per Test ³	Not Covered
Urgent Care	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$25 Per Visit ³	\$25 Per Visit ³	\$50 Per Visit ³	\$50 Per Visit ³
Emergency Room (plans with \$ copay includes all services)	\$100 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$200 Per Visit ³	\$200 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$150 Per Visit ³	\$150 Per Visit ³	\$150 Per Visit ³	\$150 Per Visit ³
Inpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	\$1,500 Per Admission ³	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Outpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered
Durable Medical Equipment	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered
Retail Pharmacy Benefits Available	7/25/45 10/20/40 10/30/50 10/35/55	Not Covered	10/30/50 10/35/55 15/35/55	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered	10/20/40 10/30/50 10/35/55 15/35/55	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered
Is this plan Medicare Part D 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.

³ Deductible does not apply.



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

SMARTCARE – HMO ¹	Smart Care Customized \$1,250 / \$30		Smart Care Customized \$1,500 / \$30		Smart Care Customized \$2,000 / \$30		Smart Care Customized \$3,000 / \$10		Smart Care Customized \$3,000 / \$30		Smart Care Customized \$4,000 / \$30	
Product Identification Number(s):	HHH20016		HHH20054		HHH20017		HHH20033		HHH20039		HHH20040	
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
Deductible	\$1,250 Individual/ \$2,500 Family	Not Covered	\$1,500 Individual/ \$3,000 Family	Not Covered	\$2,000 Individual/ \$4,000 Family	Not Covered	\$3,000 Individual/ \$6,000 Family	Not Covered	\$3,000 Individual/ \$6,000 Family	Not Covered	\$4,000 Individual/ \$8,000 Family	Not Covered
Co-Insurance	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Out-of-Pocket Maximum	\$6,350 Individual/ \$12,700 Family	Not Covered	\$4,500 Individual/ \$9,000 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,850 Individual/ \$13,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered
Preventive Care	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered	No Charge ²	Not Covered
Primary Care Provider Visit	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$10 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered
Video Visit	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Specialist Visit	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$50 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered
Diagnostic Lab	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Diagnostic X-Ray	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Imaging CT/PET/MRI	\$50 Per Test ³	Not Covered	\$200 Per Test ³	Not Covered	\$50 Per Test ³	Not Covered	\$250 Per Test ³	Not Covered	\$200 Per Test ³	Not Covered	\$200 Per Test ³	Not Covered
Urgent Care	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$50 Per Visit ³	\$50 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³
Emergency Room (plans with \$ copay includes all services)	\$100 Per Visit ³	\$100 Per Visit ³	\$200 Per Visit ³	\$200 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$250 Per Visit ³	\$250 Per Visit ³	\$300 Per Visit ³	\$300 Per Visit ³	\$300 Per Visit ³	\$300 Per Visit ³
Inpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Outpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Durable Medical Equipment	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered
Retail Pharmacy Benefits Available	10/20/40 10/30/50 10/35/55	Not Covered	10/20/40 10/30/50 10/35/55	10/20/40 10/30/50 10/35/55	10/30/50 10/35/55	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered
Is this plan Medicare Part D 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.

³ Deductible does not apply.