

SMARTCARE - HMO ¹	Smart Care \$500		Smart Care \$750		Smart Care \$1000		Smart Care \$1250		Smart Care \$2000		Smart Care \$3000		Smart Care \$4000		Smart Care \$5000		Smart Care \$6000	
Product Identification Number(s):	HHH20009		HHH20010		HHH20234		HHH20008		HHH20011		HHH20036		HHH20037		HHH20038		HHH20053	
In-Network 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	\$500 Individual/ \$ 1000 Family	Not Covered	\$750 Individual/ \$1500 Family	Not Covered	\$1000 Individual/ \$2000 Family	Not Covered	\$1250 Individual/ \$2500 Family	Not Covered	\$2000 Individual/ \$4000 Family	Not Covered	\$3000 Individual/ \$6000 Family	Not Covered	\$4000 Individual/ \$8000 Family	Not Covered	\$5000 Individual/ \$10000 Family	Not Covered	\$6000 Individual/ \$12000 Family	Not Covered
Co-Insurance	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	40% After Deductible	Not Covered	50% After Deductible	Not Covered
Out-of-Pocket Maximum	\$3000 Individual/ \$6000 Family	Not Covered	\$3250 Individual/ \$6500 Family	Not Covered	\$6350 Individual/ \$12700 Family	Not Covered	\$6350 Individual/ \$12700 Family	Not Covered	\$6350 Individual/ \$12700 Family	Not Covered	\$6350 Individual/ \$12700 Family	Not Covered	\$6350 Individual/ \$12700 Family	Not Covered	\$7000 Individual/ \$14000 Family	Not Covered	\$7500 Individual/ \$15000 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	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	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	\$20 Per Visit 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	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	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$40 Per Visit ³	Not Covered	\$50 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	No Charge ³	Not Covered	No Charge ³	Not Covered	No Charge ³	Not Covered
Diagnostic X-ray	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	40% After Deductible	Not Covered	50% After Deductible	Not Covered
Imaging CT/PET/MRI	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	40% After Deductible	Not Covered	50% After Deductible	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	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$75 Per Visit ³	\$75 Per Visit ³	\$75 Per Visit ³	\$75 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	\$100 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$100 Per Visit ³	\$200 Per Visit ³	\$200 Per Visit ³	\$200 Per Visit ³	\$200 Per Visit ³	40% After Deductible	40% After Deductible	50% After Deductible	50% After Deductible
Inpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	40% After Deductible	Not Covered	50% After Deductible	Not Covered
Outpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	40% After Deductible	Not Covered	50% 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	50% After Deductible	Not Covered	50% After Deductible	Not Covered	50% After Deductible	Not Covered
Retail Pharmacy Benefits Available	10/20/40 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 10/35/55	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	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
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 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.