



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

SMARTCARE - HMO ¹	Smart Care \$500		Smart Care \$750		Smart Care \$1,000		Smart Care \$1,250		Smart Care \$2,000		Smart Care \$3,000		Smart Care \$4,000		Smart Care \$5,000		Smart Care \$6,000		
Product Identification Number(s):	HHH20009		HHH20010		HHH20234		HHH20008		HHH20011		HHH20036		HHH20037		HHH20038		HHH20053		
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	\$500 Individual/ \$1,000 Family	Not Covered	\$750 Individual/ \$1,500 Family	Not Covered	\$1,000 Individual/ \$2,000 Family	Not Covered	\$1,250 Individual/ \$2,500 Family	Not Covered	\$2,000 Individual/ \$4,000 Family	Not Covered	\$3,000 Individual/ \$6,000 Family	Not Covered	\$4,000 Individual/ \$8,000 Family	Not Covered	\$5,000 Individual/ \$10,000 Family	Not Covered	\$6,000 Individual/ \$12,000 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	\$3,000 Individual/ \$6,000 Family	Not Covered	\$3,250 Individual/ \$6,500 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$6,350 Individual/ \$12,700 Family	Not Covered	\$7,000 Individual/ \$14,000 Family	Not Covered	\$7,500 Individual/ \$15,000 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	\$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	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	
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.

For information on Presbyterian Health Plan's Nondiscrimination Notice, go to <https://www.phs.org/nondiscrimination>.