A PRESBYTERIAN

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

VEL FUNDED SMARTCARE CUSTOMIZED- HMO ¹ \$250/\$30				Smart Care Customized \$750/\$15		Smart Care Customized \$750/\$30		Smart Care Customized \$1000/\$0		Smart Care Customized \$1000/\$20		Smart Care Customized \$1250/\$30		Smart Care Customized \$1500/\$30		Smart Care Customized \$2000/\$30		
Product Identification Number(s):	HLH20012		HLH20011		HLH20023		HLH20004				HLH20017		HLH20013				HLH20005	
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	\$250 Individual/ \$500 Family	Not Covered	\$500 Individual/ \$1000 Family	Not Covered	\$750 Individual/ \$1500 Family	Not Covered	\$750 Individual/ \$1500 Family	Not Covered	\$1000 Individual/ \$2000 Family	Not Covered	\$1000 Individual/ \$2000 Family	Not Covered	\$1250 Individual/ \$2500 Family	Not Covered	\$1500 Individual/ \$3000 Family	Not Covered	\$2000 Individual/ \$4000 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	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Out-of-Pocket Maximum	\$2750 Individual/\$ 5500 Family	Not Covered	\$3000 Individual/ \$6000 Family	Not Covered	\$6850 Individual/ \$13700 Family	Not Covered	\$3250 Individual/ \$6500 Family	Not Covered	\$6600 Individual/ \$13200 Family	Not Covered	\$3600 Individual/ \$7200 Family	Not Covered	\$6350 Individual/ \$12700 Family	Not Covered	\$4500 Individual/ \$9000 Family	Not Covered	\$6350 Individual/ \$12700 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	\$15 Per Visit ³	Not Covered	\$30 Per Visit ³	Not Covered	No Charge ³	Not Covered	\$20 Per Visit ³	Not Covered	\$30 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	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	\$40 Per Visit ³	Not Covered	\$40 Per Visit³	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	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	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	\$50 Per Test ³	Not Covered	\$200 Per Test ³	Not Covered	\$50 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 Visit³	\$40 Per Visit ³	\$40 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	\$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	\$100 Per Visit ³	\$100 Per Visit ³	\$200 Per Visit ³	\$200 Per Visit ³	\$100 Per Visit³	\$100 Per Visit ³
Inpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	\$1500 per Admission ³	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered	30% 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	50% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered	20% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Durable Medical Equipment	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	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% 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	10/20/40 10/30/50 15/35/55	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
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable		Creditable		Creditable		Creditable		Creditable		Creditable		Creditable	

PRESBYTERIAN

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

Smart Care Customized \$3000/\$10 HLH20019		Smart Care Customized \$3000/\$30 HLH20020		Smart Care Customized \$4000/\$30 HLH20021		Smart Care Customized \$5000/\$30		Smart Care Customized \$6000/\$30									
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								
\$3000 Individual/ \$6000 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								
20% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered								
\$6850 Individual/ \$13700 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								
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								
\$10 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								
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								
\$50 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								
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	No Charge ³	Not Covered								
\$250 Per Test ³	Not Covered	\$200 per test ³	Not Covered	\$200 Per Test ³	Not Covered	\$200 Per Test ³	Not Covered	\$200 Per Test ³	Not Covered								
\$50 Per Visit ³	\$50 Per Visit³	\$40 per visit ³	\$40 per visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit ³	\$40 Per Visit³	\$40 Per Visit ³	\$40 Per Visit ³								
\$250 Per Visit ³	\$250 Per Visit³	\$300 per visit ³	\$300 per visit ³	\$300 Per Visit ³	\$300 Per Visit³	\$300 Per Visit ³	\$300 Per Visit³	\$300 Per Visit ³	\$300 Per Visit ³								
20% After Deductible	Not Covered	30% after Deductible	Not Covered	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	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	30% After Deductible	Not Covered	30% After Deductible	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	Not Covered	10/20/40 10/30/50 10/35/55	Not Covered								
Cred	itable	Cred	table	Creditable		Creditable		Cred	Creditable								
	\$3000 HLH2 In Network \$3000 In Network \$3000 Individual/ \$6000 Family 20% After Deductible \$6850 Individual/ \$13700 Family No Charge2 \$10 Per Visit3 No Charge3 No Charge3 No Charge3 No Charge3 \$250 Per Visit3 No Charge3 \$250 Per Visit3 \$250 Per Visit3 \$250 Per Visit3 \$20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 10/20/40 10/30/50 10/20/40	\$3000/\$10HLH20019In NetworkOut-of-Network\$3000NotIndividual/ \$6000NotCovered\$6000FamilyNot20% After DeductibleNot Covered\$6850Not Covered\$6850Not CoveredIndividual/ \$13700Not Covered\$10 Per Visit3Not Covered\$10 Per Visit3Not Covered\$10 Per Visit3Not Covered\$10 Per Visit3Not Covered\$10 Per Visit3Not CoveredNo Charge3Not CoveredNo Charge3Not CoveredNo Charge3Not CoveredNo Charge3Not CoveredNo Charge3Not CoveredNo Charge3Not Covered\$250 Per Visit3\$250 Per Visit3\$250 Per Visit3\$250 Per Visit3\$250 Per Visit3\$250 Per Visit3\$20% After 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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 <u>www.phs.org/formsanddocuments</u>. 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 more information on Presbyterian Health Plan's Nondiscrimination Notice, go to https://www.phs.org/nondiscrimination.