PRESBYTERIAN

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

| LEVEL FUNDED SMARTCARE CUSTOMIZED-HMO[1] | Smart Care Customized $250/$30 | | Smart Care Customized $500/$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 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 | 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 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] |
| 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 Visit[3] | $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 | |
| Prescription Drug Benefit Packages - See separate benefit grid for Prescription Drug Benefit Options | | | | | | | | | | | | | | | | | | |

PRESBYTERIAN

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

| LEVEL FUNDED SMARTCARE - HMO[1] | Smart Care Customized $3000/$10 | | Smart Care Customized $3000/$30 | | Smart Care Customized $4000/$30 | | Smart Care Customized $5000/$30 | | Smart Care Customized $6000/$30 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Product Identification Number(s): | HLH20019 | | HLH20020 | | HLH20021 | | | | | | | | | | | | | |
| 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 | $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 | | | | | | | | |
| Co-Insurance | 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 | | | | | | | | |
| Out-of-Pocket Maximum | $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 | | | | | | | | |
| 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 | | | | | | | | |
| Primary Care Provider Visit | $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 | | | | | | | | |
| 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 | | | | | | | | |
| Specialist Visit | $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 | | | | | | | | |
| 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 | | | | | | | | |
| 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 | | | | | | | | |
| Imaging CT/PET/MRI | $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 | | | | | | | | |
| Urgent Care | $50 Per Visit[3] | $50 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] | | | | | | | | |
| Emergency Room (plans with $ copay includes all services) | $250 Per Visit[3] | $250 Per Visit[3] | $300 per visit[3] | $300 per visit[3] | $300 Per Visit[3] | $300 Per Visit[3] | $300 Per Visit[3] | $300 Per Visit[3] | $300 Per Visit[3] | $300 Per Visit[3] | | | | | | | | |
| Inpatient Hospital | 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 | | | | | | | | |
| Outpatient Hospital | 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 | | | | | | | | |
| Durable Medical Equipment | 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 | | | | | | | | |
| Retail Pharmacy Benefits Available | 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 | | | | | | | | |
| Is this plan Medicare Part D 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 more information on Presbyterian Health Plan's Nondiscrimination Notice, go to https://www.phs.org/nondiscrimination.