PRESBYTERIAN
Health Plan, Inc.

LEVEL FUNDED SMART CARE – HMO[1]	Smart Care $1,250 / $30		Smart Care $2,000 / $30		Smart Care $3,000 / $30		Smart Care $4,000 / $30		Smart Care $5,000 / $20		Smart Care $6,000 / $20	
Product Identification Number(s):	HLH20010		HLH20007		HLH20078		HLH20015		HLH20016		N/A	
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	$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
Coinsurance	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	$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
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	$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
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	$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
Diagnostic X-ray	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	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]	$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]	$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	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	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	40% After Deductible	Not Covered	50% After Deductible	Not Covered
Retail Pharmacy 30-day supply												
Tier 1 – Generic	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Tier 2 – Preferred Brand	$35 Copay	Not Covered	$35 Copay	Not Covered	$35 Copay	Not Covered	$35 Copay	Not Covered	$35 Copay	Not Covered	$35 Copay	Not Covered
Tier 3 – Non-Preferred	$55 Copay	Not Covered	$55 Copay	Not Covered	$55 Copay	Not Covered	$55 Copay	Not Covered	$55 Copay	Not Covered	$55 Copay	Not Covered
Tier 4 – Self-Administered Specialty	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	Not Covered	20% Coinsurance to Max. of $400 Per Prescription	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 Group 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**.
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