



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>.