PRESBYTERIAN
Health Plan, Inc.

LEVEL FUNDED SMART CARE CUSTOMIZED - HMO[1]	Smart Care Customized $250 / $30		Smart Care Customized $500 / $30		Smart Care Customized $750 / $30		Smart Care Customized $1,000/$20	
Product Identification Number(s):	HLH20012		HLH20011		HLH20004		HLH20017	
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
Deductible	$250 Individual/ $500 Family	Not Covered	$500 Individual/ 1,000 Family	Not Covered	$750 Individual/ $1,500 Family	Not Covered	$1,000 Individual/ $2,000 Family	Not Covered
Coinsurance	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered
Out-of-Pocket Maximum	$2,750 Individual/ $5,500 Family	Not Covered	$3,000 Individual/ $6,000 Family	Not Covered	$3,250 Individual/ $6,500 Family	Not Covered	$3,600 Individual/ $7,200 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
Primary Care Provider Visit	$30 Per Visit[3]	Not Covered	$30 Per Visit[3]	Not Covered	$30 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
Specialist Visit	$40 Per Visit[3]	Not Covered	$40 Per Visit[3]	Not Covered	$40 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
Diagnostic X-ray	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	$50 Per Test[3]	Not Covered	$250 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]	$50 Per Visit[3]	$50 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]	$150 Per Visit[3]	$150 Per Visit[3]
Inpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered
Outpatient Hospital	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% After Deductible	Not Covered
Durable Medical Equipment	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	20% 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
Tier 2 – Preferred Brand	$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
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
Is this plan Medicare Part D 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.
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MPC042655

PRESBYTERIAN
Health Plan, Inc.

LEVEL FUNDED SMART CARE CUSTOMIZED - HMO[1]	Smart Care Customized $1,250 / $30		Smart Care Customized $1,500 / $30		Smart Care Customized $2,000 / $30		Smart Care Customized $3,000 / $30	
Product Identification Number(s):	HLH20013		N/A		HLH20005		HLH20020	
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
Deductible	$1,250 Individual/ $2,500 Family	Not Covered	$1,500 Individual/ $3,000 Family	Not Covered	$2,000 Individual/ $4,000 Family	Not Covered	$3,000 Individual/ $6,000 Family	Not Covered
Coinsurance	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Out-of-Pocket Maximum	$6,350 Individual/ $12,700 Family	Not Covered	$4,500 Individual/ $9,000 Family	Not Covered	$6,350 Individual/ $12,700 Family	Not Covered	$6,350 Individual/ $12,700 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
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
Video Visit	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
Diagnostic Lab	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
Imaging CT/PET/MRI	$50 Per Test[3]	Not Covered	$200 Per Test[3]	Not Covered	$50 Per Test[3]	Not Covered	$200 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]
Emergency Room (plans with $ copay includes all services)	$100 Per Visit[3]	$100 Per Visit[3]	$200 Per Visit[3]	$200 Per Visit[3]	$100 Per Visit[3]	$100 Per Visit[3]	$300 Per Visit[3]	$300 Per Visit[3]
Inpatient Hospital	30% 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	30% After Deductible	Not Covered	30% 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
Retail Pharmacy 30-day supply								
Tier 1 – Generic	$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
Tier 3 – Non-Preferred	$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
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable		Creditable	
Prescription Drug Benefit Packages – See separate benefit grid for Prescription Drug Benefit Options								

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[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.
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LEVEL FUNDED SMART CARE CUSTOMIZED - HMO[1]	Smart Care Customized $4,000 / $30		Smart Care Customized $5,000 / $30		Smart Care Customized $5,000 / $30		Smart Care Customized $5,000 / $30	
Product Identification Number(s):	HLH20021		N/A		N/A		HLH20099	
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
Deductible	$4,000 Individual/ $8,000 Family	Not Covered	$5,000 Individual/ $10,000 Family	Not Covered	$5,000 Individual/ $10,000 Family	Not Covered	$5,000 Individual/ $10,000 Family	Not Covered
Coinsurance	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Out-of-Pocket Maximum	$6,350 Individual/ $12,700 Family	Not Covered	$7,000 Individual/ $14,000 Family	Not Covered	$7,000 Individual/ $14,000 Family	Not Covered	$7,000 Individual/ $14,000 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
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
Video Visit	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
Diagnostic Lab	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
Imaging CT/PET/MRI	$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	$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)	$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	30% 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	30% After Deductible	Not Covered	30% 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
Retail Pharmacy 30-day supply								
Tier 1 – Generic	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Tier 2 – Preferred Brand	$35 Copay	Not Covered	$20 Copay	Not Covered	$30 Copay	Not Covered	$35 Copay	Not Covered
Tier 3 – Non-Preferred	$55 Copay	Not Covered	$40 Copay	Not Covered	$50 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
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable		Creditable	
Prescription Drug Benefit Packages – See separate benefit grid for Prescription Drug Benefit Options								

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LEVEL FUNDED SMART CARE CUSTOMIZED - HMO[1]	Smart Care Customized $6,000 / $30		Smart Care Customized $6,000 / $30		Smart Care Customized $6,000 / $30	
Product Identification Number(s):	N/A		N/A		N/A	
In- or Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$6,000 Individual/ $12,000 Family	Not Covered	$6,000 Individual/ $12,000 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
Out-of-Pocket Maximum	$7,500 Individual/ $15,000 Family	Not Covered	$7,500 Individual/ $15,000 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
Primary Care Provider Visit	$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
Specialist Visit	$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
Diagnostic X-ray	No Charge[3]	Not Covered	No Charge[3]	Not Covered	No Charge[3]	Not Covered
Imaging CT/PET/MRI	$200 Per Test[3]	Not Covered	$200 Per Test[3]	Not Covered	$200 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]
Emergency Room (plans with $ copay includes all services)	$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	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	30% After Deductible	Not Covered
Durable Medical Equipment	30% After Deductible	Not Covered	30% After Deductible	Not Covered	30% After Deductible	Not Covered
Retail Pharmacy 30-day supply						
Tier 1 – Generic	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Tier 2 – Preferred Brand	$20 Copay	Not Covered	$30 Copay	Not Covered	$35 Copay	Not Covered
Tier 3 – Non-Preferred	$40 Copay	Not Covered	$50 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
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable	
Prescription Drug Benefit Packages – See separate benefit grid for Prescription Drug Benefit Options						

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