PRESBYTERIAN

Offered by Presbyterian Health Plan

SMART CARE Small Group HMO Benefit Plans

Benefit	Smart Care HMO Plans (HHH: 10039, 10040)	Smart Care HMO Plans (HHH: 10038, 10041, 10073, 10074)
Annual Calendar Year Deductible	HHH10039 – Individual: $500 HHH10040 – Individual: $750 Family: x3 (Individual)	HHH10038 – Individual: $1,250 HHH10041 – Individual: $2,000 HHH10073 – Individual: $2,500 HHH10074 – Individual: $5,000 Family: x3 (Individual)
Annual Out-of-Pocket Maximum (Includes % Copayments which are subject to Deductible only – does **not** include Deductible, all other Copayments, or non-Covered charges.)	Individual: $2,000 Family: x3 (Individual)	Individual: $4,500 Family: x3 (Individual)
Maximum Lifetime Benefit	Unlimited	Unlimited
Physician Services		
Primary Care Physician (PCP) office visit (OV)	$30	$30
Specialist office visit (OV)	$40	$40
Home Visits	**Not Covered**	**Not Covered**
Outpatient Surgery (In Physician's office)	Included in OV copay	Included in OV copay
Hospital and Skilled Nursing Visits	30%(2)	30%(2)
Specialty Pharmaceuticals (1) (Injectable forms administered in Physician's office)	15% up to a maximum of $250 per injection and $1,500 per Calendar Year	15% up to a maximum of $250 per injection and $1,500 per Calendar Year
Allergy Services		
Testing	30%	30%
Serum (extracts)	30%	30%
Injections (Copay waived if nursing visit only)	Included in OV copay	Included in OV copay
Injections such as insulin, heparin, and injectable antibiotics	Included in OV copay	Included in OV copay
Infertility Services including drugs and injections	50%	50%
On-Campus Student Health Center	$30	$30
Hospital Inpatient Services (1)		
Room and Board	30%(2)	30%(2)
Inpatient Physician Care	30%(2)	30%(2)
Hospital Outpatient Services		
Surgeries (1) (at facility)	30%(2)	30%(2)
Diagnostic Tests: X-Ray / MRI (1) / PET (1) / CAT (1) Scans, Cardiac Cath/GI Lab	30%(2)	30%(2)
Diagnostic Tests: Lab	0%	0%
Emergency Room Care (Including trauma services)	$100	$100
Urgent Care		
Participating and Non-Participating Provider/ Practitioner (In or out of the Service Area)	$40	$40
Ambulance Services including:		
Emergency Ground/Air	$50/$100	$50/$100
High-risk Inter-Facility Transfer Services Ground/Air	$0 /$100	$0 /$100
Clinical Preventive Services		
Well Child Care	$30	$30
Preventive Physical Exam	$30	$30
Adult and Child Immunizations	Included in OV copay	Included in OV copay
Pap Smear	Included in OV copay	Included in OV copay
Mammography	$0	$0
Colonoscopy	$0	$0

(1) Benefit Certification may be required. (2) Subject to Deductible.

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SMART CARE Small Group HMO Benefit Plans

Benefit	Smart Care HMO Plans (HHH: 10039, 10040)	Smart Care HMO Plans (HHH: 10038, 10041, 10073, 10074)
Diabetes Services		
Diabetes Education and Office Visit	$30 per visit	$30 per visit
Women's Health Care		
Gynecological Care	$30	$30
In office Obstetrical/Maternity Care	$30 to $300 maximum	$30 to $300 maximum
Specialist (Perinatologist)	$40 per visit	$40 per visit
Delivery [1]	30%[2]	30%[2]
Prescription Drugs (Retail/Mail Order)		
Generic (Preferred)	$10 / 2x	$10 / 2x
Brand (Preferred)	$35 / 2.5x	$35 / 2.5x
Non-Preferred	$55 / 3x	$55 / 3x
Specialty Pharmaceuticals [1]	15% up to a maximum of $250 per prescription and $1,500 per Calendar Year	15% up to a maximum of $250 per prescription and $1,500 per Calendar Year
Mental Health Services [1]		
Outpatient	$40	$40
Inpatient and partial hospitalization	30%[2]	30%[2]
Substance Abuse Services [1]		
Detoxification only - Inpatient and Outpatient	30%[2]	30%[2]
Additional rehabilitation coverage	**Not Covered**	**Not Covered**[)]
Complementary Therapies (Limited)		
Acupuncture (20 sessions/Calendar Year)	30%[2]	30%[2]
Chiropractic (18 sessions/Calendar Year)	30%[2]	30%[2]
Rehabilitation and Therapy Services		
Cardiac Rehabilitation	30%[2]	30%[2]
Dialysis/Plasmapheresis/Photophoresis	30%[2]	30%[2]
Pulmonary Rehabilitation	30%[2]	30%[2]
Short-term Rehabilitation [1] (Physical and Occupational Therapy up to 2 months per condition)		
Inpatient	30%[2]	30%[2]
Outpatient	30%[2]	30%[2]
Speech [1] and Hearing Therapy [1] (up to 2 months per condition)	30%[2]	30%[2]
Hospice Care [1]		
Inpatient	30%[2]	30%[2]
In-home	30%[2]	30%[2]
Skilled Nursing Facility [1] (up to 60 days per Calendar Year)	30%[2]	30%[2]
Transplants [1]	30%[2] (Standard Coverage)	30%[2] (Standard Coverage)
Durable Medical Equipment [1]	50% copay[2] ($2,000/Calendar Year Maximum) Diabetic supplies do not count toward the Calendar Year Maximum benefit.	50% copay[2] ($2,000/Calendar Year Maximum) Diabetic supplies do not count toward the Calendar Year Maximum benefit.
Vision Services	**Please refer to the Optional Benefit Rider Materials**	

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