



Rates are effective  
June 1, 2024

**2024/2025 Rates**  
**Smart Health Plans**  
**RBP - PHCS/Multiplan PPO Plan Options**  
**12 Month Rate Guarantee**

Plan Name:	\$1,500 Classic		\$2,500 Classic		\$3,500 Classic	
Network Search:	<a href="http://www.multiplan.us">www.multiplan.us</a>		<a href="http://www.multiplan.us">www.multiplan.us</a>		<a href="http://www.multiplan.us">www.multiplan.us</a>	
States Available:	Available in 50 States		Available in 50 States		Available in 50 States	
Lifetime Maximum:	No Maximum		No Maximum		No Maximum	
	In-Network Benefits	Non-Network Benefits	In-Network Benefits	Non-Network Benefits	In-Network Benefits	Non-Network Benefits
Referrals Needed:	No		No		No	
Preventative Care:	Covered		Covered		Covered	
Deductible: Individual/Family	\$1,500/\$3,000	\$3,000/\$6,000	\$2,500/\$5,000	\$5,000/\$10,000	\$3,500/\$7,000	\$7,000/\$14,000
Out of Pocket Max: Individual/Family	\$7,350/\$14,700	\$20,000/\$40,000	\$7,350/\$14,700	\$20,000/\$40,000	\$7,350/\$14,700	\$20,000/\$40,000
Office Co-payments:	PCP \$40 copay Specialist \$80 copay		PCP \$40 copay Specialist \$80 copay		PCP \$45 copay Specialist \$90 copay	
Mental Health: (Out-Patient)	\$40 copay		\$40 copay		\$45 copay	
Hospital: (In-Patient)	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Prescription Benefits:						
Generic:	\$15 copay		\$15 copay		\$15 copay	
Preferred Brand:	\$45 copay		\$45 copay		\$65 copay	
Non-Preferred Brand:	\$85 copay		\$85 copay		\$100 copay	
Specialty:	No Covered		Not Covered		Not Covered	
Emergency Medical Transportation:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Emergency Room:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
X-Ray, Bloodwork:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Advanced Imaging:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Urgent Care:	\$80 copay		\$80 copay		\$90 copay	
Child Eye Exam:	Not Covered		Not Covered		Not Covered	
Child Dental Exam:	Not Covered		Not Covered		Not Covered	
Durable Medical:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Home Health Care:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Hospital Stay:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
Physician and Surgeon Fees:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	
SBC:	<a href="#">SHP PHCS 1500 Classic</a>		<a href="#">SHP PHCS 2500 Classic</a>		<a href="#">SHP PHCS 3500 Classic</a>	
Sample Monthly Cost	\$1,500 Classic		\$2,500 Classic		\$3,500 Classic	
Member Only:	\$960.00		\$886.00		\$780.00	
Member + Spouse:	\$1,894.00		\$1,745.00		\$1,532.00	
Member + Child(ren):	\$1,707.00		\$1,573.00		\$1,382.00	
Member + Family:	\$2,827.00		\$2,604.00		\$2,285.00	
Notes:	<p>One-Time Processing Fee: \$125            12 month rate guarantee            Deductible and MOOP reset every January 1st            Pricing is subject to change pending the results of the underwriting process            This is for illustration purposes only            This is only a snapshot of the benefits            ***SEE SBC FOR LIMITATIONS, EXCEPTIONS and OTHER IMPORTANT INFORMATION***            Online Rates and SBC supersede this summary</p>					





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**2024/2025 Rates  
Smart Health Plans  
RBP - PHCS/Multiplan PPO Plan Options  
12 Month Rate Guarantee**

Plan Name:	\$5,000 Classic		HSA \$5,000		\$7,350 Classic	
Network Search:	<a href="http://www.multiplan.us">www.multiplan.us</a>		<a href="http://www.multiplan.us">www.multiplan.us</a>		<a href="http://www.multiplan.us">www.multiplan.us</a>	
States Available:	Available in 50 States		Available in 50 States		Available in 50 States	
Lifetime Maximum:	No Maximum		No Maximum		No Maximum	
	In-Network Benefits	Non-Network Benefits	In-Network Benefits	Non-Network Benefits	In-Network Benefits	Non-Network Benefits
Referrals Needed:	No		No		No	
Preventative Care:	Covered		Covered		Covered	
Deductible: Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000	\$5,000/\$10,000	\$10,000/\$20,000	\$7,350/\$14,700	\$14,700/\$29,400
Out of Pocket Max: Individual/Family	\$7,350/\$14,700	\$20,000/\$40,000	\$7,350/\$14,700	\$20,000/\$40,000	\$7,350/\$14,700	\$20,000/\$40,000
Office Co-payments:	PCP \$45 copay Specialist \$90 copay		PCP & Specialist Deductible then 20% coinsurance		PCP \$50 copay Specialist \$100 copay	
Mental Health: (Out-Patient)	\$45 copay		Deductible then 20% coinsurance		\$50 copay	
Hospital: (In-Patient)	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Prescription Benefits:						
Generic:	\$15 copay		Discount Card		Discount Card	
Preferred Brand:	\$65 copay		Discount Card		Discount Card	
Non-Preferred Brand:	\$100 copay		Discount Card		Discount Card	
Specialty:	Not Covered		Discount Card		Discount Card	
Emergency Medical Transportation:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Emergency Room:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
X-Ray, Bloodwork:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Advanced Imaging:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Urgent Care:	\$90 copay		\$80 copay		\$100 copay	
Child Eye Exam:	Not Covered		Not Covered		Not Covered	
Child Dental Exam:	Not Covered		Not Covered		Not Covered	
Durable Medical:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Home Health Care:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Hospital Stay:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
Physician and Surgeon Fees:	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 0%	
SBC:	<a href="#">SHP PHCS 5000 Classic</a>		<a href="#">SHP PHCS 5000 HSA</a>		<a href="#">SHP PHCS 7350 Classic</a>	
Sample Monthly Cost	\$5,000 Classic		HSA \$5,000		\$7,350 Classic	
Member Only:	\$717.00		\$655.00		\$579.00	
Member + Spouse:	\$1,407.00		\$1,283.00		\$1,130.00	
Member + Child(ren):	\$1,269.00		\$1,158.00		\$1,020.00	
Member + Family:	\$2,096.00		\$1,911.00		\$1,682.00	

**Notes:**  
 One-Time Processing Fee: \$125  
 12 month rate guarantee  
 Deductible and MOOP reset every January 1st  
 Pricing is subject to change pending the results of the underwriting process  
 This is for illustration purposes only  
 This is only a snapshot of the benefits  
 \*\*\*SEE SBC FOR LIMITATIONS, EXCEPTIONS and OTHER IMPORTANT INFORMATION\*\*\*  
 Online Rates and SBC supersede this summary

