PRESBYTERIAN
Health Plan, Inc.

VANTAGE HDHP-HSA Eligible HMO[1]	Vantage HDHP-HSA Eligible HMO $2,000 / 0%		Vantage HDHP-HSA Eligible HMO $2,000 / 20%		Vantage HDHP-HSA Eligible HMO $3,500 / 0%		Vantage HDHP-HSA Eligible HMO $3,500 / 30%		Vantage HDHP-HSA Eligible HMO $3,500 / 50%	
Product Identification Number(s):	HHH20291		HHH20292		HHH20296		HHH20297		HHH20417	
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
Deductible	$2,000 Individual/ $4,000 Family	Not Covered	$2,000 Individual/ $4,000 Family	Not Covered	$3,500 Individual/ $7,000 Family	Not Covered	$3,500 Individual/ $7,000 Family	Not Covered	$3,500 Individual/ $7,000 Family	Not Covered
Coinsurance	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Out-of-Pocket Maximum	$2,000 Individual/ $4,000 Family	Not Covered	$4,000 Individual/ $8,000 Family	Not Covered	$3,500 Individual/ $7,000 Family	Not Covered	$6,350 Individual/ $12,700 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	No Charge[2]	Not Covered
Primary Care Provider Visit	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Specialist Visit	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Diagnostic Lab	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Diagnostic X-ray	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Imaging CT/PET/MRI	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Urgent Care	No Charge After Deductible	No Charge After Deductible	20% After Deductible	20% After Deductible	No Charge After Deductible	No Charge After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Emergency Room	No Charge After Deductible	No Charge After Deductible	20% After Deductible	20% After Deductible	No Charge After Deductible	No Charge After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Inpatient Hospital	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Outpatient Hospital	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After eductible	Not Covered	50% After Deductible	Not Covered
Durable Medical Equipment	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Retail Pharmacy 30-day supply										
Tier 1 – Generic	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Tier 2 – Preferred Brand	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Tier 3 – Non-Preferred	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Tier 4 – Self-Administered Specialty	No Charge After Deductible	Not Covered	20% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	50% After Deductible	Not Covered
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable		Creditable		Creditable	
Embedded Deductible and Out-of-Pocket Maximum	No		No		Yes		Yes		Yes	
This plan is a Qualified High Deductible Plan (HDHP) – Qualified high deductible health plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity®, members can conveniently open an HSA to pay for qualified Out-of-Pocket medical expenses tax-free. To learn more, visit **www.healthequity.com** or call 1-866-346-5800.										

[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.

For information on Presbyterian Health Plan's Nondiscrimination Notice, go to **https://www.phs.org/nondiscrimination**.

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VANTAGE HDHP-HSA Eligible HMO[1]	Vantage HDHP-HSA Eligible HMO $4,000 / 0%		Vantage HDHP-HSA Eligible HMO $4,000 / 30%		Vantage HDHP-HSA Eligible HMO $5,000 / 0%		Vantage HDHP-HSA Eligible HMO $5,000 / 30%	
Product Identification Number(s):	HHH20298		HHH20299		HHH20300		HHH20301	
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	$4,000 Individual/ $8,000 Family	Not Covered	$5,000 Individual/ $10,000 Family	Not Covered	$5,000 Individual/ $10,000 Family	Not Covered
Coinsurance	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered
Out-of-Pocket Maximum	$4,000 Individual/ $8,000 Family	Not Covered	$6,350 Individual/ $12,700 Family	Not Covered	$5,000 Individual/ $10,000 Family	Not Covered	$7,500 Individual/ $15,000 Family	Not Covered
Preventive Care	No Charge[1]	Not Covered	No Charge[2]	Not Covered	No Charge[2]	Not Covered	No Charge[2]	Not Covered
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Tier 3 – Non-Preferred	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered
Tier 4 – Self-Administered Specialty	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered	No Charge After Deductible	Not Covered	30% After Deductible	Not Covered
Is this plan Medicare Part D Creditable?	Creditable		Creditable		Creditable		Creditable	
Embedded Deductible and Out-of-Pocket Maximum	Yes		Yes		Yes		Yes	

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