PRESBYTERIAN Health Plan, Inc. 2021 HMO Individual and Family Plan

CALENDAR YEAR BENEFITS	Silver 1 High Deductible Health Plan (HDHP)[1]
A **deductible** is the amount you pay before the plan pays for benefits with coinsurance (%). The family deductible is 2x the individual deductible.	$3,200
What do I pay for covered benefits?	**Copayment or Coinsurance[2]**
Preventive Care[3]	You pay $0
Primary Care Provider Visit	20%
Urgent Care	20%
Video Visit	$40 until deductible is met, then 0%
Specialist Visit	20%
Mental Health Outpatient Services	20%
Lab	20%
X-Ray	20%
Imaging CT/PET/MRI	20%
Emergency Room	20%
Hospital Inpatient or Outpatient	20%
Chiropractic and Acupuncture Limited to 20 visits each	20%
Rehabilitation Therapy Physical, Occupational and Speech	20%
Prescription Drugs (30-day supply)	
Tier 1: Preferred Generic	0%
Tier 2: Non-Preferred Generic	20%
Tier 3: Preferred Brand	20%
Tier 4: Non-Preferred Drug	20%
Tier 5: Specialty Pharmaceuticals	20%
Out-of-Pocket (OOP) Maximum	
The **OOP max** includes the deductible, copayments, coinsurance and prescription drug costs that you pay. The family OOP is 2x the individual out-of-pocket maximum.	$7,000
Additional Benefits	
Fitness Center Membership, Standard Dental, Vision for Children, Basic Vision, and Rewards are included.[4]	

1. High Deductible Health Plan - Qualified high deductible health plans can be used with a member-owned, portable Health Savings Account (HSA). Through our partnership with HealthEquity, you can conveniently open an HSA to pay for your insurance deductible and qualified out-of-pocket medical expenses tax-free. To learn more, visit **www.healthequity.com** or call 1-866-346-5800.
2. Copayment – Benefits with a copayment ($) are not subject to deductible. Copayment covers office visit only. All other services are subject to deductible and/or coinsurance.
   Coinsurance – Benefits with a coinsurance (%) are subject to deductible first, and then you pay the applicable coinsurance (%) amount.
3. You pay $0 - Plan pays 100% for Clinical Preventive Health Services such as physical exam, colonoscopy and routine immunizations.
4. See flyers for details

Summary of Benefits

Standard Class Dental Plan *Included at no additional cost*	**You Pay:**	
	In-Network	**Out-of-Network**
Preventive (each service 1 per calendar year per enrolled member) • Comprehensive or Periodic Oral Examination • Child or Adult prophylaxis cleaning • Bitewing X-Rays (4 films)	0%	20% (MAC)*

Premium Dental Plan	**You Pay:**	
	In-Network	**Out-of-Network**
Class I: (Preventive Care) • Oral Examinations • 2nd Cleaning • Fluoride Treatment • Space Maintainers • Sealants • Palliative Emergency Treatment • Dental X-rays	0%	20% (MAC)*
Class II: (Basic) • Oral Surgery • Extractions • Restorations (Fillings) • Anesthesia (in conjunction with oral surgery)	20%* (MAC)*	50%* (MAC)*
Class III: (Major)** Crowns • Bridges • Dentures • Inlays • Partial Dentures Other prosthetic Services • Endodontic Services • Periodontal Services	50%* (MAC)*	75% (MAC)*

- **Maximum Allowable Charge (MAC)*** - This PPO Plan will pay the applicable percentage of the contracted rate as determined by the PPO agreement between BenefitSource and the Preferred Provider.
- **Class III: (Major)**** services are subject to a six-month waiting period from the effective date of coverage. Members must be covered under the plan for six consecutive months in order to be eligible for Class III (Major) services.
- **Maximum Benefit** per calendar year for all Class I, II and III expenses……$1,000 per person
- **Deductible** applicable to Class II and III covered expenses..... $50 per person
  Deductible is based on calendar year with a maximum of three (3) deductibles per family ($150)

Monthly Premium	
Single	$18.15
Two Enrolled	$35.05
Three or More Enrolled	$59.17

Limitations

Covered Expenses will not include and no benefits will be payable: 1) for any procedure not listed in the List of Covered Dental Expense Procedures; 2) for any procedure performed more frequently than once per Calendar Year; 3) for any procedure begun before the policy owner was covered under this section; 4) for any procedure begun after the policy owner's insurance under this section terminates; 5) for education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control; 6) for the completion of claim forms; 7) for charges for which the policy owner is not liable or which would not have been made had no insurance been in force; 8) for services which are not recommended by a dentist or which are not required for necessary care and treatment; 9) to a policy owner if payment is not legal where the policy owner is living when expenses are incurred; 10) Any services related to: equilibration; bite registration or bite analysis.

Presbyterian Health Plan is the medical carrier that markets these dental plans. BenefitSource Inc. owns the dental network and provides administration. Companion Life Insurance Company underwrites the dental plans. The above provides only a brief description of your dental plan. Please refer to the policy Form 535 INDV NM for complete details including limitations and exclusions. For more information, please contact BenefitSource toll-free at 1-888-862-8659.

For a current list of PPO providers, please visit our website at www.BenefitSource.org.

1804 Juan Tabo NE, Suite A, Albuquerque, NM 87112
Phone: (505) 237-1501 or 1-888-862-8659 **Fax:** (505) 237-8344

Summary of Benefits

Vision for Children and Vision Basic plans are included at no additional cost.

In-network benefits	**Vision for Children** (included for children up to age 19)	**Vision Basic** (included for all members age 19+)
Frequencies		
Eye exam	12 months	12 months
Spectacle lenses	12 months	N/A
Frame	12 months	N/A
Contact lens evaluation, fitting and follow-up care	12 months	N/A
Copayments		
Eye exam	$0	$0
Spectacle lenses	$0	SV $45 / BF $65 / TF $95 / CA $120
Contact lens evaluation, fitting and follow-up care	$0	N/A
Coverage		
Frame allowance (retail):	Up to $100, plus 20% discount on any overages	35% off provider's U&C (usual and customary)
Davis Vision frame collection (in lieu of allowance):**		
Fashion Level	$0 Copay	N/A
Designer Level	$15 Copay	N/A
Premier Level	$40 Copay	N/A
Contact lenses: materials allowance	Up to $100, plus 15% discount on any overages	15% off provider's U&C (usual and customary)
Laser Benefit		
One-time/lifetime allowance	N/A	N/A
Eyeglass Benefit – Spectacle Lenses		
Digital single vision (intermediate)	$30	$30
Scratch-resistant coating	Covered	$15
Polycarbonate lenses (child/adult)	Covered	$35
Standard anti-reflective (AR) coating	$40	$45
Standard progressive lenses	$65	$65
Out-of-Network Reimbursements		
Eye exam	$55	$55
Frame	$50	N/A
Single vision lenses	$40	N/A
Bifocal/progressive lenses	$60	N/A
Progressive lenses	N/A	N/A

The benefit information provided is a brief summary, not a comprehensive description of all benefits, limitations and or exclusions. For more information, call 1-800-999-5431 or refer to the policy at davisvision.com/presbyterian.