Individual and Family Plan-Child Only
HMO
(HHH10155)

The following *Summary of Benefits* is a summary that describes your Cost Sharing amounts that apply to specific types of services. Some benefits require Prior Authorization by Presbyterian Health Plan, Inc. (PHP). Benefits may have limits and certain services are excluded altogether. For a more complete description, please refer to Sections of the *Subscriber Agreement* that discuss How the Plan Works, Benefits, Prior Authorization, Limitations and Exclusions.

Underwritten by
Presbyterian Health Plan, Inc. (PHP)

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
What is your Annual Calendar Year Deductible?	Individual: $1,250

The Annual Calendar Year Deductible is the amount you and your Covered Dependents must pay for Covered Health Care Services each Calendar Year before we begin to pay Covered Benefits for that Member.

- If you have single Coverage, you must meet the Annual Individual Deductible requirement during the Calendar Year.
- If you have double or family Coverage, when you and a Dependent are both Members, you both must meet the Annual Individual Deductible during the Calendar Year.
- If you have family Coverage, when you and two (or more) dependents are Members, any three Members must meet the Annual Individual Deductible during the Calendar Year.

Covered charges for In-network Practitioner and Provider services only apply to the In-network Annual Calendar Year Deductible limits.

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
What is your Annual Out-of-pocket Maximum?	Individual: $4,000

This Plan includes an Annual Out-of-pocket Maximum amount to help protect you and your Covered Dependents from high-cost catastrophic Health Care expenses. The Annual Out-of-pocket Maximum is the most you will pay in Coinsurance Cost Sharing in a Calendar Year for certain Covered Services. After your Deductible has been met, your annual Coinsurance expenses accumulate (add up) toward your Annual Out-of-pocket Maximum. After you have met your Annual Out-of-pocket Maximum in a Calendar Year, we pay 100% of the cost for Covered Services, for the remainder of that Calendar Year, up to the maximum benefit amount, if any.

The Annual Out-of-pocket Maximum amount only includes Coinsurance Cost Sharing and **does not include**: Deductible, Copayments Charges above Usual, Reasonable and Customary, Medical Drug Copayments, or Prescription Drugs (including Specialty Pharmaceuticals) Copayments or non-covered charges incurred after the benefit maximum has been reached. Any amounts paid for additional benefit riders, such as Dental do not count toward the Annual Out-of-pocket Maximum.

- If you have single Coverage, you must meet the Annual Individual Out-of-pocket Maximum requirement during the Calendar Year.
- If you have double or family Coverage, when you and a Dependent are both Members, you both must meet the Annual Individual Out-of-pocket Maximum during the Calendar Year.
- If you have family Coverage, when you and two (or more) dependents are Members, any three Members must meet the Annual Individual Out-of-pocket during the Calendar Year.

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Maximum Lifetime Benefit (Does not include Family, Infant and Toddler (FIT) Program services and Autism Spectrum Disorder)	Unlimited
Autism Spectrum Disorder Diagnosis and Treatment Maximum Lifetime Benefit Diagnosis for Treatment for all children up to age 19 or up to age 22 if still attending high school up to $36,000 per member per Calendar Year combined In- and Out-of-network. Not applicable to any other Annual Limits.	$200,000 per member per lifetime combined In- and Out-of-network. (Does not apply to Plan Lifetime Maximum). Beginning January1, 2011 the maximum benefit shall be adjusted manually on January 1 to reflect any change from the previous year in the medical component of the then-current price index for all urban consumers published by the Bureau of Labor Statistics of the United States Department of Labor.
Pre-existing Limitation (Does not apply to newborns and newly adopted children)	• No pre-existing limitation for members under age 19 • No pre-existing if prior (creditable) coverage
Annual Calendar Year DME Benefit Maximum	$1,000/year (does not cover pre-existing conditions)
Maximum Lifetime Hospice Benefit	$7,500
What are your Covered Benefits?	**Copayment/Coinsurance**
Practitioner/Provider Services	
Non-specialist office visits	$25[(2) (*)] Copayment per visit
Specialist office visits	30% Coinsurance
Applied Behavioral Analysis (ABA) – for Autism Only[(1)]	$25 Copayment per visit[(2)(*)] (*Copayment is for the office visit **only**. All other services received during the office visit are subject to Deductible, Coinsurance and Copayments)
Outpatient surgery (In Physician's office)	30% Coinsurance
Medical Drugs[(1)] (Drugs administered in Physician's Office, including Chemotherapy Drugs)	20% Coinsurance (up to the maximum of $400 per medication and $2,500 per Calendar Year. Once the maximum is met by the Member, the plan pays 100% of allowed charges for the remainder of the Calendar Year
Allergy Services –Office Visits	30% Coinsurance
Testing/Serum	30% Coinsurance
Injections	30% Coinsurance
Infertility Services including, but not limited to, testing, drugs and injections	Not Covered

[(1)] Prior Authorization will be required [(2)] Not subject to Deductible Eff. 1/13/2013

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Clinical Preventive Services Well child care including vision and hearing screening Preventive physical examinations and screenings Adult and child immunizations Health education Family planning services Cytologic screening (Pap Smear) Human Papillomavirus (HPV) Screening HPV Vaccine Mammography Colonoscopy	Plan Pays 100%[2]
Diagnostic Services	30% Coinsurance
Bone density studies[1]	30% Coinsurance
Clinical laboratory tests	30% Coinsurance
Computerized Axial Tomography (CAT) scans [1]	30% Coinsurance
Gastrointestinal lab procedures[1]	30% Coinsurance
Magnetic Resonance Angiogram (MRA) tests/Magnetic Resonance Imaging (MRI) tests[1]	30% Coinsurance
Positron Emission Tomography (PET) scans[1]	30% Coinsurance
Pulmonary function tests[1]	30% Coinsurance
Radiology/X-ray services	30% Coinsurance
Home/Outpatient Sleep disorder studies[1]	Not Covered
Prescription Drugs/Medications – Retail – Covered Medications – Outpatient[1][2]	
Listed on the PHP Preferred Drug List (Purchased at a Participating Pharmacy, unless due to an emergency occurring outside the PHP Service Area) Prescription Drug Coinsurance is not subject to either the Deductible or Out-of-pocket maximum.	
• Medically Necessary Nutritional Supplements for prenatal care • Insulin and diabetic oral agents • Diabetic supplies (Purchased through a Participating Pharmacy) • Smoking cessation drugs (Limited to two 90-day courses of treatment per Calendar Year) ***Continued on next page***	$10 Generic (Preferred) $35 Brand (Preferred) Brand plus the difference in the cost of the brand and generic (when a generic equivalent is available) $75 Non-Preferred (Copayment per 30-day supply up to the maximum dosing recommended by the manufacturer)

[1] Prior Authorization will be required [2] Not subject to Deductible Eff. 1/13/2013

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Prescription Drugs/Medications – Retail - Covered Medications – Outpatient[1][2] ***Continued from previous page***	
• Contraceptive Methods Preferred Generic birth control ▪ Cyclafem 1/35 ▪ Cyclafem 7/7/7 ▪ Emoquette ▪ Gildess FE 1.5/30 ▪ Gildess FE 1/20 ▪ Orsythia ▪ Previfem ▪ Tri-Previfem ▪ Myzilra Intrauterine devices (IUD) ▪ Implantable • Nexplanon (Implanon) ▪ Intrauterine • Mirena • Paragard Contraceptive injections ▪ Medroxyprogesterone acetate injection	Plan Pays 100%[2]
• Specialty Pharmaceuticals	20% up to a maximum of 400 per medication and $2,500 per Calendar Year. Once the maximum is met by the Member, the plan pays 100% of allowed charges for the remainder of the Calendar Year.
• Special Medical Foods	50% Coinsurance

[1] Prior Authorization will be required [2] Not subject to Deductible

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Prescription Drugs/Medications - Mail Order	
• Generic (Preferred – Tier 1	2x generic Copayment (per 90-day supply up to the maximum dosing recommended by the manufacturer)
• Brand (Preferred) – Tier 2	2.5x brand Copayment (90-day supply up to the maximum dosing recommendation by manufacturer)
• Brand (when a generic equivalent is not available)	Brand Copayment plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)
• Non-Preferred – Tier 3	3x non-preferred Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)
• Specialty Pharmaceuticals – Tier 4	Specialty pharmaceuticals are not available through mail order. They must be obtained through designated specialty pharmacy vendors and may be subject to prior authorization.
Outpatient Medical Services	30% Coinsurance
Outpatient Surgeries[(1)]	30% Coinsurance
Radiation therapy (Non-surgical)	30% Coinsurance
Chemotherapy	30% Coinsurance
Medical Drugs[(1)] (Drugs administered in Physician's office, including Chemotherapy Drugs)	20% up to a maximum of $400 per medication and $2,500 per Calendar Year. Once the maximum is met by the Member, the plan pays 100% of allowed charges for the remainder of the Calendar Year.
Short-term Acute Medical Detoxification	30% Coinsurance per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Deductible, Coinsurance and Copayments)
• Outpatient	30% Coinsurance per admission
• Inpatient	30% Coinsurance per admission
• Partial Hospitalization (Waive if immediately following an inpatient hospital discharge)	30% Coinsurance
Outpatient Facility Observation (Prior Authorization is required if Observation greater than 24 hours)	
Emergency Room Care Including trauma services	$100[(2)] Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies) ER visit only; all other services received during the ER visit are subject to Deductible and Coinsurance

[(1)] Prior Authorization will be required [(2)] Not subject to Deductible Eff. 1/13/2013

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Ambulance Services including:	30% Coinsurance
Emergency or High Risk	
• Ground	
• Air Ambulance	
Inter-facility transfer services [1]	30% Coinsurance
• Ground	
• Air Ambulance	
Urgent Care Center	$50[2] Copayment per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to Deductible and applicable In or Out-of-network Coinsurance)
Hospital Services – Inpatient [1] Coverage includes: • Room and board • In-hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient services Acute Medical Detoxification	30% Coinsurance
Reconstructive Surgery [1]	30% Coinsurance
Mental Health Services and Medications [1]	**Not Covered**
Alcohol and Substance Abuse Services[1]	
Rehabilitation-Outpatient, Inpatient or partial hospitalization	Not Covered
Short-term Acute Medical Detoxification	
• Outpatient • Inpatient	30% Coinsurance

[1] Prior Authorization will be required [2] Not subject to Deductible

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Women's Health Care	
Gynecological care	
• Well-women visits	Plan Pays 100%[2]
• Non-specialist office visits	$25[2] Copayment per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to Deductible, Coinsurance and Copayments)
• Specialist office visits	30% Coinsurance
• Contraceptive Methods Preferred Generic birth control ▪ Cyclafem 1/35 ▪ Cyclafem 7/7/7 ▪ Emoquette ▪ Gildess FE 1.5/30 ▪ Gildess FE 1/20 ▪ Orsythia ▪ Previfem ▪ Tri-Previfem ▪ Myzilra Intrauterine devices (IUD) ▪ Implantable • Nexplanon (Implanon) ▪ Intrauterine • Mirena • Paragard Contraceptive injections ▪ Medroxyprogesterone acetate injection	Plan Pays 100%[2]
In office obstetrical/maternity care/prenatal and postnatal care	Not Covered
Newborn delivery and other hospital Obstetrical services	Not Covered
Breastfeeding support/supplies and counseling (for 1 year after delivery)	Plan Pays 100%[2]

[1] Prior Authorization will be required [2] Not subject to Deductible Eff. 1/13/2013

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Home Healthcare Services/Home Intravenous Services [1]	
Services provided by an RN, LPN and other specified specialist (Up to 100 visits per Calendar Year)	30% Coinsurance
Home intravenous services and supplies (Up to 100 days per Calendar Year)	30% Coinsurance
Rehabilitation and Therapy Services[1]	
Cardiac Rehabilitation (Up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year)	30% Coinsurance
Dialysis/Plasmapheresis/Photopheresis	30% Coinsurance
Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)	30% Coinsurance
Short-term Rehabilitation (up to $500 per Calendar Year combined) Physical and Occupational Therapy	30% Coinsurance
Speech and Hearing Therapy (up to $500 per Calendar Year combined)	30% Coinsurance
Skilled Nursing Facility[1] (Up to 60 days per Calendar Year)	30% Coinsurance
Diabetes Services	
Office visit and Diabetes Education	$25[2] Copayment per visit (Copayment is for the office visit only. All other services received during the office visit are subject to Deductible, Coinsurance and Copayments)
Certified Diabetes Educators Telephonic visits	Plan Pays 100%[2]
Diabetes Supplies (Purchased through a Durable Medical Equipment provider) (Diabetic supplies do not count toward the Calendar Year Maximum benefit).	30% Coinsurance

[1] Prior Authorization will be required [2] Not subject to Deductible

Individual and Family Plan-Child Only HMO (HHH10155)	Limits
Durable Medical Equipment, Prosthetics, Orthotics and Appliances[(1)] Oxygen and Equipment – included in the Durable Medical Equipment benefit	30% Coinsurance ($1,000 Maximum Benefit per Member per Calendar Year)
Hearing Aids (for school aged children under age 18 or 21 years of age if still attending high school)	Up to $2,200 every 36 months "per hearing impaired ear".
Certified Hospice Care[(1)] (Subject to lifetime maximum)	30% Coinsurance
Transplants[(1)]	30% Coinsurance
Eyeglasses and Contact Lenses Limited to the following:	
• Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus[(1)]	30% Coinsurance
• Eye Refraction Exam associated with post cataract surgery or Keratoconus correction	30% Coinsurance
Dental Services(Limited)/CMJ/TMJ[**(1)**]	30% Coinsurance
Family, Infant and Toddler Program Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.	No Coinsurance $3,500 per Member per Calendar Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits
Complementary Therapies (Limited)	
Acupuncture treatment (maximum $1,500 per Calendar Year)	30% Coinsurance
Chiropractic services (maximum $1,500 per Calendar Year)	30% Coinsurance

EXCLUSIONS FOR PREFERRED CARE Individual and Family Plan-Child Only HMO (HHH10155):

This Section lists services that are Not Covered under your Health Benefit Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be excluded.

- **Alcoholism and Substance Abuse services** except for Short-term Acute Medical Detoxification
- Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not Medically Necessary is not Covered, except for Preventive services.
- **Ambulance Services** (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.
- **Autopsies -** costs for deceased Members are not Covered.
- **Bariatric Surgery** – is not Covered, except as defined in the *Subscriber Agreement.*
- **Before or After the Effective Date of Coverage -** Services received, items purchased, prescriptions filled or health care expenses incurred before your effective date of Coverage or after termination of your Coverage are not Covered.
- **Biofeedback**
- **Cancer Clinical Trials** except as specified in the *Subscriber Agreement.*
- **Care for military service connected disabilities -** to which you are legally entitled and for which facilities are reasonably available to you is not Covered.
- **Certified Hospice Care benefits** are not Covered for the following services:
  - Food, housing, and delivered meals.
  - Volunteer services.
  - Personal or comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits).
  - Homemaker and housekeeping services.
  - Private duty nursing.
  - Pastoral and spiritual counseling.
  - Bereavement counseling.
- **Charges in excess of Usual, Customary and Reasonable or Unreasonable -** Charges that we determine to be in excess of Usual, Customary and Reasonable Charges and charges we determine to be unreasonable are not Covered.
- **Circumcisions** performed other than during the newborn's initial Hospital stay, are not Covered unless Medically Necessary.
- **Clothing or other protective devices**, including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not, are not Covered.
- **Clinical Preventive Services**
  - **Physical examinations, vaccinations, drugs and immunizations** for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to employment are not Covered.
  - **Immunizations** for the purpose of foreign travel are not Covered.
- **Complementary Therapies**, except those specified in the *Subscriber Agreement* are not Covered.

- **Cosmetic Surgery** - is not Covered.
- **Cosmetic treatments, devices, orthotics, and medications** are not Covered.
- **Costs for extended warranties and premiums for other insurance coverage** are not Covered.
- **Dental Services**
  - **Dental care and dental X-rays** are not Covered, except as provided in the *Subscriber Agreement*.
  - **Dental implants** are not Covered.
  - **Malocclusion treatment**, if part of routine dental care and orthodontics, is not Covered.
  - **Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures** used for the treatment of Temporo/Craniomandibular Joint disorders are not Covered, unless the disorder is trauma related.
- **Diabetes Services -** Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses is not Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.
- **Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids.**
  - **Durable Medical Equipment**:
    - Upgraded or deluxe Durable Medical Equipment is not Covered.
    - Convenience items are not Covered.
    - Duplicate Durable Medical Equipment items (i.e. for home and office) are not Covered.
  - **Repair and Replacement:**
    - Repair or replacement of Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience is not Covered.
    - Repair and replacement of items under the manufacturer or supplier's warranty are not Covered.
    - Additional wheelchairs are not Covered, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.
  - **Orthotic Appliances:**
    - Functional foot orthotics including those for plantar fascitis, pes planus (flat feet), heel spurs and other conditions (as we determine), Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints are not Covered, except for patients with diabetes or other significant peripheral neuropathies.
    - Custom-fitted Orthotics/Orthosis are not Covered except for knee-ankle-foot (KAFO) Orthosis and/or ankle-foot Orthosis (AFO) except for Members who meet national recognized guidelines and require Prior Authorization for the Orthotics.
  - **Prosthetic Devices -** Artificial aids including speech synthesis devices are not Covered, except items identified as being Covered in the *Subscriber Agreement.*
  - **Surgical Dressing:**
    - Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as 4 by 4's), and ace bandages are not Covered, except when provided in a Hospital or Practitioner/Provider's office or by a home health professional.
    - Gloves are not Covered, unless part of a wound treatment kit.
    - Elastic Support hose are not Covered.
  - **Eyeglasses and Contact Lenses:**

- Routine vision care and Eye Refractions for determining prescriptions for corrective lenses are not Covered, except as identified in the *Subscriber Agreement*.
- Corrective eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, are not Covered except as identified in the *Subscriber Agreement.*
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques are not Covered.
- Visual training is not Covered.
- Eye movement therapy is not Covered.

- **Emergency Health Care Services -** Use of an emergency facility for non-emergent services is not Covered.
- **Exercise equipment**, **Personal Trainers, Club Memberships**, videos and weight reduction programs are not Covered.
- **Experimental or Investigational drugs, medicines, treatments, procedures, or devices** as indicated in the *Subscriber Agreement.*
- **Extracorporeal shock wave therapy** involving the musculoskeletal system is not Covered.
- **Foot Care -** Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses is not Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.
- **Genetic Inborn Errors of Metabolism Coverage does not include the following items.**
  - Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other Over-the-counter (OTC) digestive aids are not Covered, unless listed as a Covered OTC medication on our Formulary.
  - Ordinary foodstuffs that might be part of an exclusionary diet are not Covered.
  - Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM are not Covered.
  - Special Medical Foods for conditions that are not present at birth are not Covered.
  - Dietary supplements and items for conditions including, but not limited to, Diabetes mellitus, Hypertension, Hyperlipidemia, Obesity, Autism, Celiac Disease and Allergies to food products are not Covered.
- **Hair-loss (or baldness)** treatments, medications, supplies and devices, including wigs, and special brushes are not Covered regardless of the medical cause of the hair-loss or baldness.
- **Home Health Care Services/Home Intravenous Services and Supplies**
  - Private duty nursing is not Covered.
  - Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for Home Health Care Services and are not Covered.
- **Home/Outpatient Sleep disorder studies**
- **Hospital Services**
  - Acute Medical Detoxification in a Residential Treatment Center is not Covered.
  - Rehabilitation is not Covered as part of acute medical detoxification.
- **Mental Health Services including medications.**
- **New medications** for which the determination of criteria for Coverage has not yet been established by PHP's Pharmacy and Therapeutics Committee.
- **Nutritional Support and Supplements**
  Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings is not Covered.
- **Prescription Drugs/Medications**

- Compounded Prescription Drugs are not Covered.
- New Medications for which the determination of criteria for Coverage has not yet been established by our Pharmacy and Therapeutics Committee are not Covered.
- Over-the-counter (OTC) medications and drugs for which there is a non-prescriptive equivalent available are not Covered.
- Prescription Drugs/Medications that require a Prior Authorization when Prior Authorization was not obtained are not Covered.
- Prescriptions purchased outside the United States are not Covered, unless required due to an Emergency occurring outside of the Service Area.
- Replacement prescriptions resulting from loss, theft, or destruction are not Covered.
- Prescription Drugs/Medications, medicines, treatments, procedures, or devices that we determine are Experimental or Investigational are not Covered.
- Disposable medical supplies, except when provided in a Hospital or a Practitioner/Provider's office or by a home health professional, are not Covered.
- Treatments and medications for the purpose of weight reduction or control, except for Medically Necessary treatment for morbid obesity, are not Covered.
- Nutritional supplements unless for prenatal care as prescribed by the attending Practitioner/Provider or as sole source of nutrition are not Covered. Infant formula is **not Covered** under any circumstance.
- Prescription Drugs/Medications used for the treatment of sexual dysfunction are not Covered.
- Prescription Drugs/Medications used for cosmetic purposes are not Covered.

- **Practitioner/Provider Services –** services provided by an excluded provider are not Covered. Any benefit or service, including pharmaceuticals, provided by an Excluded Provider as defined and maintained by the following regulatory agencies: Department of Health and Human Services, Office of the Inspector General (OIG); U.S. Department of Health; the General Services Administration; and the Office of Personnel Management, Office of Inspector General, which includes, but is not limited to, the:
  - Excluded Parties Lists System (EPLS),
  - List of Excluded Individuals/Entities (LEIE),
  - Office of Personnel Management (OPM).
  - **Office Visits**, listed below, are not Covered:
    - Telephone visits, except for Members that have been diagnosed with diabetes.
    - Electronic mail (E-mail) by a Practitioner/Provider or consultation by telephone for which a charge is made to the patient.
    - Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.
  - **Infertility services, listed below, are not Covered.**
    - Reversal of voluntary sterilization.
    - Donor sperm.
    - In-vitro, *Gamete Intra Fallopian Transfer (*GIFT) and zygote intrafallopian transfer (ZIFT) fertilization.
    - Infertility Services.
    - Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue.
- **Reconstructive Surgery for Cosmetic purposes is not Covered -** Cosmetic Surgery is not Covered. Examples of Cosmetic Surgery include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.

- **Rehabilitation and Therapy, as listed below, is not Covered**
  - Short or Long-term Rehabilitation:
    - Athletic trainers or treatments delivered by Athletic trainers.
    - Vocational Rehabilitation Services.
    - Long-term Rehabilitation services. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief.
    - Treatment of chronic conditions.
    - Vocational Rehabilitation Services.
  - **Speech Therapy services listed below are not Covered:**
    - Therapy for stuttering.
    - Hearing aids and the evaluation for the fitting of hearing aids are not Covered, except for school aged children under 18 years old (or under 21 years of age if still attending high school).
- **Services for which you or your Dependent are eligible under any governmental program** (except Medicaid), to the extent determined by law, are not Covered. Services for which, in the absence of any health service plan or insurance plan, no charge would be made to you or your Dependent, are not Covered.
- **Services, other than emergent or urgent in nature, received outside of the United States** are not Covered.
- **Services requiring Prior Authorization when Out-of-network** and Prior Authorization was not obtained are not Covered.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics, are not Covered, except for penile prosthesis as listed under Durable Medical Equipment in the Benefits Section.
- **Sex transformation -** Surgery and drugs related to sex transformation are not Covered.
- **Skilled Nursing Facility Care -** Custodial or Domiciliary care is not Covered.
- **Smoking Cessation services listed below are not Covered:**
  - Hypnotherapy for Smoking Cessation Counseling.
  - Over-the-counter (OTC) drugs, unless listed as a Covered OTC medication on our Formulary.
  - Acupuncture for Smoking Cessation Counseling.
- **Thermography Services are not Covered.**
- **Transplant Services listed below are not Covered:**
  - Non-human Organ transplants, except for porcine (pig) heart valve.
  - Transportation costs for deceased Members.
  - The medical and Hospital services of an Organ transplant donor when the recipient of an Organ transplant is not a Member or when the transplant procedure is not Covered.
  - Travel and lodging expenses are not Covered except as provided in the *Subscriber Agreement*.
- **Treatment while incarcerated –** services or supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison are not Covered.
- **Women's Health Care**
  - Elective abortions are not Covered.
  - Maternity care

- **Work-related illnesses or injuries are not Covered**, even if:
  - You fail to file a claim within the filing period allowed by the applicable law.
  - You obtain care not authorized by Workers' Compensation Insurance.
  - Your employer fails to carry the required Worker's Compensation Insurance.
  - You fail to comply with any other provisions of the law.

Any exclusion listed would not be applicable if Covered under the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services. Refer to your Subscriber Agreement for details.

Refer to the Subscriber Agreement for a more complete description of Exclusions and Limitations.

This Summary of Benefits and services is subject to the provisions of the contract and cannot modify or affect the Subscriber Agreement in any way; nor shall you accrue rights because of any statement in or omission from this Summary.

Plan ID's –HHH10228 (for internal use)

DELTA DENTAL®

DENTAL PLANS

Benefits underwritten by Delta Dental of New Mexico

featuring the Delta Dental PPO℠ and Delta Dental Premier® provider networks

STANDARD DENTAL PLAN **(Presbyterian Individual and Family Plan automatically includes these dental benefits. Members may elect the Comprehensive Dental Plan below.)**	**If you go to a Delta Dental PPO Dentist**	**If you go to a Delta Dental Premier Dentist**
Diagnostic and Preventive Services:	**You Pay**	**You Pay**
• Oral Examinations - once in a benefit year	$ 0	20 %
• Routine Cleaning – once in a benefit period for members without a Specified Medical Condition	$ 0	20 %
• Routine or Periodontal Cleaning – once in a benefit period for members diagnosed with a Specified Medical Condition	$ 0	20 %
• X-rays - full mouth series once every 5 years/Bitewings - once in a benefit year	$ 0	20 %
• Fluoride Application- through age 18, once in a benefit year	$ 0	20 %
• Emergency Treatment - for relief of pain	$ 0	20 %
• Sealants - through age 15, permanent molars only, 3 year limitation	$ 0	20 %
• Space Maintainers - through age 13	$ 0	20 %
Additional Services covered if member has a diagnosed *Specified Medical Condition:*		
• Two (2) Additional Routine Cleanings – for members without periodontal disease	$ 0	20 %
• Two (2) Additional Routine or Periodontal Cleanings –for members diagnosed with periodontal disease	$ 0	20 %
• Periodontics – other non-surgical and surgical	50 %	50 %
Craniomandibular (CMJ) and Temporomandibular Joint (TMJ) Disorders:		
• Specified services, subject to clinical review; with some services benefited only if the disorder is trauma related	50 %	50 %
COMPREHENSIVE DENTAL PLAN **(includes benefits shown above and in this section; additional premium applies as shown below)**	**If you go to a Delta Dental PPO Dentist**	**If you go to a Delta Dental Premier Dentist**
Basic and Restorative Services:		
• Amalgam fillings – anterior and posterior teeth	20 %	40 %
• Composite resin fillings - anterior and posterior teeth	20 %	40 %
• Stainless steel crowns	20 %	40 %
• Extractions - non-surgical	20 %	40 %
• Oral Surgery - maxillofacial surgical procedures of the oral cavity, including surgical extractions	20 %	40 %
• Endodontics - pulp therapy and root canal filling	20 %	40 %
• Periodontics - non-surgical and surgical	20 %	40 %
• General Anesthesia - intravenous sedation and general anesthesia, when dentally necessary and administered by a licensed provider for a covered oral surgery procedure	20 %	40 %
Major Services – A six (6) month Benefit Waiting Period applies to these services:		
• Crowns and Cast Restorations, including repairs - when teeth cannot be restored with amalgam or composite resin restorations	50 %	50 %
• Prosthodontics - procedures for construction or repair of fixed bridges, partials or complete dentures	50 %	50 %
• Implants – specified services, including repairs, and related prosthodontics, subject to clinical review/approval	50 %	50 %

ADDITIONAL MEMBER PREMIUM FOR COMPREHENSIVE DENTAL PLAN FOR SELECT PLAN: $21.00

Dental Plan Deductible: A $50 calendar year deductible ($150 per Family) applies only to the services in the grey shaded boxes shown above.

Maximum Benefit Amount / Benefit Period: $1,000 per enrolled person per calendar year.

DELTA DENTAL®

DENTAL PLANS

Benefits underwritten by Delta Dental of New Mexico

featuring the Delta Dental PPO℠ and Delta Dental Premier® provider networks

Page 2 of 2 dental plan pages (please refer to page 1 of the dental plan illustration for a Summary of Benefits)

Provider Networks: Delta Dental has more than one provider network. Although benefits apply when services are received from either a Delta Dental PPO or Delta Dental Premier dentist, the highest level of benefits applies in the Delta Dental PPO network. Delta Dental PPO is a national provider network with more than 168,000 dentist locations -- over 1265 of them in New Mexico. For the most updated list of participating providers, visit DeltaDentalNM.com. Click on Find a Dentist in the Members' section, select the New Mexico Provider Directories link and then click on Delta Dental PPO.

Participating providers may not charge patients for amounts above the applicable Delta Dental Maximum Approved Fee. Dentists who do not participate in either Delta Dental PPO or Delta Dental Premier (non-participating dentists) are subject to reduced Maximum Approved Fees and may balance bill patients up to their submitted fees; out-of-pocket cost may be significantly higher.

Special Eligibility Provisions: dental plan eligibility and enrollment is tied to enrollment in a **Presbyterian Individual and Family Plan** which is underwritten by Presbyterian Health Plan.

Specified Medical Conditions: Enrollees with Specified Medical Conditions have increased dental plan benefits, as noted on the Summary of Benefits page. Specified Medical Conditions are diagnoses of pregnancy, diabetes or HIV-AIDS. Members receiving chemotherapy treatment also qualify for the additional benefits which require a Specified Medical Condition.

Special Benefit Provisions:

Standard Dental Plan benefits are automatically included, without additional premium, for **Presbyterian Individual and Family Plan** members. **Standard Dental Plan** benefits are designed to provide coverage for routine preventive dental care. Some additional benefits are provided for members with Specified Medical Conditions, but there is no coverage for the Restorative, Basic, and Major Services which are covered under the **Comprehensive Dental Plan**. Note: when the **Comprehensive Dental Plan** is elected, all covered Periodontal Services (except additional routine or Periodontal Cleanings) are available without the requirement for a diagnosis of a Specified Medical Condition.

The **Comprehensive Dental Plan** (both the white and grey areas of the Summary of Benefits) is available as an option for any **Presbyterian Individual and Family Plan** member.

- ✓ **Presbyterian Individual and Family Plan** members may elect **Comprehensive Dental Plan** benefits when they first enroll. Later enrollment is only available when offered by Presbyterian as part of an annual enrollment opportunity.
- ✓ Benefits for Orthodontic Services are not included and are not available as an option.
- ✓ No dental coverage applies to any dental care services received prior to enrollment.
- ✓ The premiums applicable to elect the **Comprehensive Dental Plan** are shown at the bottom of the Summary of Benefits page.

BENEFIT WAITING PERIOD: A six (6) month Benefit Waiting Period applies to the Major Services which are covered under the **Comprehensive Dental Plan**. This waiting period applies when initially enrolled under the **Comprehensive Dental Plan**, and to any re-enrollment in the **Comprehensive Dental Plan** following any break in coverage.

PRE-TREATMENT ESTIMATE: is available anytime more costly dental procedures are anticipated. When requested by a dentist, an advance estimate of benefits payable can be provided by Delta Dental before dental care services are received. Pre-treatment estimate is strongly recommended and there is no charge for this service.

When Coverage Ends – Coverage under the **Standard Dental Plan** ends when no longer enrolled in the **Presbyterian Individual and Family Plan**. Coverage under the **Comprehensive Dental Plan** ends on the last day of any contract period during which **Comprehensive Dental Plan** benefits were elected or when no longer enrolled in the **Presbyterian Individual and Family Plan**, whichever comes first.

Need more general information or help enrolling?
Call the Presbyterian Individual Plan Call Center at 866-8MY-PRES.

To view all medical and dental coverage options or apply online,
follow the Individual Plan links at www.phs.org.

For detailed questions specific to the dental plan benefits,
call Delta Dental Customer Services at 505-855-7111 or (if outside Albuquerque) at 877-395-9420.

Oral health is an important part of overall health. Enroll today!

Medical coverage under Presbyterian Individual Medical Plan is underwritten and administered by Presbyterian Health Plan. Dental care benefits are underwritten by Delta Dental of New Mexico / 2500 Louisiana Blvd NE #600, Albuquerque, New Mexico 87110.

The Summary of Benefits on Page 1 and the additional information on this page are designed to provide an overview of dental plan benefits. These pages do not reflect all limitations or exclusions or provide complete dental coverage information. Once enrolled, members receive all dental plan provisions included in a benefit booklet.

Choice Exam Plus Plan

Prepared for Presbyterian Health Plan

The Choice Exam Plus Plan includes a covered in full eye exam and discounts on eyewear through a Vision Service Plan, Inc. (VSP) Choice Preferred Provider[1], or a set exam allowance through any other provider.

Provider Choices	**VSP Choice Preferred Providers** • 46,000 access points nationwide. VSP doctors are located in retail, neighborhood, medical and professional settings.
Benefits through a VSP Choice Preferred Provider	
Exam Services	Comprehensive WellVision Exam® covered-in-full once every 12 months after a $15.00 copay
Discounts on Glasses	• 20% off complete pairs of prescription glasses • 20% off all lens options • 20% off unlimited non-prescription sunglasses[2]
Contact Lenses	• 15% off contact lens exam, excluding materials • Exclusive offers for VSP members include: Mail-in rebate savings[4] up to $110 on eligible Bausch & Lomb contacts and up to $125 on eligible ACUVUE Brand Contact Lenses[3]
VSP Laser VisionCare℠ Program	Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, and Custom Lasik[4]
Open Access Schedule	Reimbursement schedule for services from other providers: Exam - $45

Exclusions

The following items are excluded under this plan:

- Services and/or materials not indicated on this schedule as covered plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter),
- Two pair of glasses instead of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing or cleaning.
- Services associated with CRT or Orthokeratology.
- Artistically painted or non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification
- Polishing or cleaning.

[1] Plan available through various provider networks including the VSP Network, Choice Network, and Advantage Network.
[2] Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.
[3] Rebates subject to change.

[4] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. LaserVision Care discounts are only available from VSP-contracted facilities.