Schedule of Benefits

CLASSIC $5,000/70%
WITHOUT COMPREHENSIVE DENTAL
PPO
(IIP10182)

The following Schedule of Benefits is a summary that describes the Co-insurance and or Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PIC. 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, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

Underwritten by
Presbyterian Insurance Company, Inc. (PIC)
Delta Dental Plan of New Mexico, Inc.

Classic without Dental (IIP10182) Medical Benefits And Coverage	In-Network Limits	Out-of-Network Limits
ANNUAL CALENDAR YEAR DEDUCTIBLE (Deductible must be met before payments are made.)	Individual: $5,000 Family: x3 (Individual)	Individual: $10,000 Family: x3 (Individual)
ANNUAL OUT-OF-POCKET MAXIMUM (Includes Co-insurance only. **Does not include** Deductible, Copayments, penalty amounts, charges above Reasonable and Customary, prescription drug Copayment, Medical Drug copayment or non-covered charges including charges incurred after the benefit maximum has been reached.) PIC pays 100% of Covered charges after the Out-of-Pocket maximum is met.	Individual: $4,000 Family: x3 (Individual)	Individual: $ 6,000 Family: x3 (Individual)
PRE-EXISTING LIMITATION (Does not apply to newborns, and newly adopted children – **pregnancy and pregnancy-related conditions are not covered under this plan**)	• No pre-existing limitation for dependent children under age 19 • No pre-existing limitation if prior (creditable) coverage • 6 months	
MAXIMUM LIFETIME BENEFIT	Unlimited	
AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT MAXIMUM LIFETIME BENEFIT	$200,000 per member per lifetime. Beginning January 1, 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 consumer price index for all urban consumers published by the Bureau of Labor Statistics of the United States Department of Labor.	
MAXIMUM LIFETIME HOSPICE BENEFIT	$7,500 In-Network and Out-of-Network combined	
BENEFITS AND COVERAGE	**In-Network Copayment/Co-insurance**	**Out-of-Network Copayment/Co-insurance**
PHYSICIAN SERVICES including: Office Visits Non-specialist office visits Specialist office visits	 $25(2) Copayment per visit $40(2) Copayment per visit **3 visits per Calendar year (combined).** Copayment is for the office visit only. All other services received during the office visit are subject to the Deductible and Co-insurance. **Subsequent visits are subject to the Deductible and Co-insurance**	 50% Co-insurance 50% Co-insurance
Outpatient surgery (In-Physician's office)	30% Co-insurance	50% Co-insurance
Allergy services Testing Serum (extracts) Injections	30% Co-insurance	50% Co-insurance
Infertility services including, but not limited to, testing, drugs and injections	**Not Covered**	**Not Covered**

(1) Benefit Certification will be required.(2) Not subject to Deductible
Refer to the Subscriber Agreement for a more complete description of benefits.

Classic without Dental (IIP10182) Medical Benefits And Coverage	In-Network Copayment/Co-insurance	Out-of-Network Copayment/Co-insurance
HOSPITAL SERVICES – Inpatient[1] Coverage includes: • Room and board • In-hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient services (Hospital charges for delivery or pregnancy related conditions are not covered) • Detoxification	30% Co-insurance	50% Co-insurance
MEDICAL SERVICES – Outpatient		
• Surgeries[1]	30% Co-insurance	50% Co-insurance
• X-ray and laboratory tests	30% Co-insurance	50% Co-insurance
• Radiation therapy (non-surgical)	30% Co-insurance	50% Co-insurance
• Chemotherapy	30% Co-insurance	50% Co-insurance
• Medical Drugs[1] provided or administered in an Outpatient setting	20% Copayment up to a maximum of $400 per injection and $2,500 per Calendar Year	20% Copayment up to a maximum of $400 per injection
• Computed Axial Tomography (CAT)[1] scans	30% Co-insurance	50% Co-insurance
• Positron Emission Tomography (PET)[1] scans	30% Co-insurance	50% Co-insurance
• Magnetic Resonance Imaging (MRI)[1] tests	30% Co-insurance	50% Co-insurance
• Sleep studies	**Not Covered**	**Not Covered**
• Administration of blood/blood components	30% Co-insurance	50% Co-insurance
• Observation (Benefit Certification required if greater than 24 hours)	30% Co-insurance	50% Co-insurance
RECONSTRUCTIVE SURGERY[1]	30% Co-insurance	50% Co-insurance
EMERGENCY ROOM CARE Including trauma services	$150[2] Copayment per visit – **1 visit per Calendar year.** (Copayment is for the ER visit **only**. All other services received during the ER visit are subject to Deductible and Co-insurance.) **Subsequent ER visits are subject to the Deductible and Co-insurance**	
URGENT CARE	$50[2] Copayment per visits – **2 visits per Calendar year** (Copayment is for the Urgent Care visit only. All other services received during the Urgent Care visit are subject to Deductible and applicable In- or Out-of-network Co-insurance.) **Subsequent Urgent Care visits are subject to the Deductible and Co-insurance**	
AMBULANCE SERVICES including: Emergency or high risk • Ground ambulance • Air ambulance Inter-facility transfer Services • Ground ambulance • Air ambulance	30% Co-insurance	30% Co-insurance

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Classic without Dental (IIP10182) Medical Benefits And Coverage	In-Network Copayment/Co-insurance	Out-of-Network Copayment/Co-insurance
CLINICAL PREVENTIVE SERVICES Well child care including vision and hearing screening Preventive physical exam Adult and child immunizations Office based health education Family planning services Cytologic Screening (Pap smear) Human Papillomavirus (HPV) HPV Vaccine for females Mammography Colonoscopy	Plan pays 100%(2)	50% Co-insurance
WOMEN'S HEALTH CARE Gynecological care Implantable contraceptive device *Please refer to Clinical Preventive Services for Cytologic (Pap Smear), Human Papillomavirus (HPV) screening, and Mammograms	$25(2) Copayment per visit. **3 visits per Calendar year (combined).** Copayment is for the office visits only. All other services received during the office visit are subject to the Deductible and Co-insurance. **Subsequent visits are subject to the Deductible and Co-insurance**	50% Co-insurance
Specialist (Perinatologist)	30% Co-insurance	50% Co-insurance
Obstetrical/Maternity/Prenatal and Postnatal Care	**Not Covered**	**Not Covered**
DIABETES SERVICES Office visit and Diabetes education	$25(2) Copayment per visit. **3 visits per Calendar year (combined).** Copayment is for the office visits only. All other services received during the office visit are subject to the Deductible and Co-insurance. **Subsequent visits are subject to the Deductible and Co-insurance**	50% Co-insurance
Certified Diabetic Educator telephone calls	$0(2) Copayment	50% Co-insurance
Diabetes supplies(1) (Purchased through a Durable Medical Equipment provider)	30% Co-insurance	50% Co-insurance
***Diabetes Services** continued on next page*		

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Classic without Dental (IIP10182) Medical Benefits And Coverage	In-Network Copayment/Co-insurance	Out-of-Network Copayment/Co-insurance
DIABETES SERVICES *continued from previous page*		
Diabetes supplies[1,2] (Purchased through a Participating Pharmacy)	$10 Generic (Preferred) $35 Brand (Preferred) $75 Non-Preferred Per 30-day supply up to the maximum dosing recommended by the manufacturer	**Not Covered** (Must use Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area.)
COVERED MEDICATIONS[1,2] - Outpatient		
• 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) • Contraceptive Drugs	$10 Generic (Preferred) $35 Brand (Preferred) $75 Non-Preferred Per 30-day supply up to the maximum dosing recommended by the manufacturer	**Not Covered** (Must use Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area.)
Immunosuppressive drugs following transplant surgery[1,2]		
• Oral	$10 Generic (Preferred) $35 Brand (Preferred) $75 Non-Preferred Per 30-day supply [up to the maximum dosing recommended by the manufacturer	
• Injectable	20% Copayment up to a maximum of $400 per injection and $2,500 per Calendar Year	
• Specialty Pharmaceuticals[1,2]	20% Copayment up to a maximum of $400 per injection and $2,500 per Calendar Year	
• Specialty Medical Foods[1,2]	50% Copayment	
For plans with "Covered Medication" coverage only this plan is considered Creditable per Medicare part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov. If your employer has purchased the Optional Prescription Drug Rider please refer to that Rider for Medicare Part D Creditable/Non-Creditable status.		
PRESCRIPTION DRUGS[1,2] Prescription Drugs (Retail/Mail Order) – Outpatient	**Not Covered** except as provided in the Covered Medication Section of the Subscriber Agreement, unless the Optional Benefit Rider is included, then the Copayments listed in the Rider will supersede.	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area)
MENTAL HEALTH SERVICES AND MEDICATIONS	**Not Covered**	**Not Covered**

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Classic without Dental (IIP10182) Medical Benefits And Coverage	In-Network Copayment/Co-insurance	Out-of-Network Copayment/Co-insurance
ALCOHOL AND SUBSTANCE ABUSE SERVICES		
Rehabilitation - Outpatient, Inpatient or partial hospitalization	**Not Covered**	**Not Covered**
Detoxification		
• Outpatient(1)	30% Co-insurance	50% Co-insurance
• Inpatient(1)	30% Co-insurance	50% Co-insurance
REHABILITATION AND THERAPY SERVICES		
Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions for intermittent ECG monitoring per Calendar Year)	30% Co-insurance	50% Co-insurance
Dialysis/Plasmapheresis/Photopheresis	30% Co-insurance	50% Co-insurance
Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)	30% Co-insurance	50% Co-insurance
Short-term Rehabilitation (Physical and Occupational therapy up to 2 months per condition)	30% Co-insurance	50% Co-insurance
Speech(1) and Hearing Therapy(1) (up to 2 months per condition)	30% Co-insurance	50% Co-insurance
TRANSPLANTS(1)	30% Co-insurance	**Not Covered**
COMPLEMENTARY THERAPIES (Limited)		
Acupuncture treatment (maximum $1,500 per Calendar Year)	30% Co-insurance	**Not Covered**
Chiropractic services (maximum $1,500 per Calendar Year)	30% Co-insurance	**Not Covered**
SKILLED NURSING FACILITY(1) (Up to 60 days per Calendar Year)	30% Co-insurance	50% Co-insurance
HOME HEALTHCARE SERVICES/ HOME INTRAVENOUS SERVICE (1)		
Services provided by an RN, LPN and other specified specialist (Up to 100 visits per Calendar Year)	30% Co-insurance	50% Co-insurance
Home intravenous services and supplies (up to 100 days per Calendar Year)	30% Co-insurance	50% Co-insurance
HOSPICE CARE(1) (Subject to lifetime maximum)	30% Co-insurance	50% Co-insurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND APPLIANCES(1)	30% Co-insurance	50% Co-insurance
	($1,000 Maximum Benefit Per member Per Calendar Year Combined In and Out-of-network – Maximum does not apply to supplies for Members with diabetes)	
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".	

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Classic without Dental (IIP10182) Medical Benefits And Coverage	In-Network Copayment/Co-insurance	Out-of-Network Copayment/Co-insurance
EYEGLASSES AND CONTACT LENSES Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus • Refraction eye Exam associated with post cataract surgery or Keratonconus correction	30% Co-insurance 30% Co-insurance	**Not Covered** **Not Covered**
DENTAL SERVICES (LIMITED) **CMJ/TMJ**	30% Co-insurance 30% Co-insurance	**Not Covered** 50% Co-insurance
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 Co-insurance. $3,500 per Member per Calendar Year Maximum annual benefit. Not applicable to any lifetime maximums or annual limits.	
AUTISM SPECTRUM DISORDER (1) Treatment through or provided by: PCP Specialist Applied Behavioral Analysis (ABA) (1)	$25 (2) Copayment per visit $40 (2) Copayment per visit $25 (2) Copayment per visit **3 visits per Calendar year (combined).** Copayment is for the office visits **only**. All other services received during the office visit are subject to the Deductible and Co-insurance. **Subsequent visits are subject to the Deductible and Co-insurance**	50% Co-insurance 50% Co-insurance 50% Co-insurance
Outpatient Physical therapy Outpatient Occupational therapy Outpatient Speech therapy	30% Co-insurance 30% Co-insurance 30% Co-insurance	50% Co-insurance 50% Co-insurance 50% Co-insurance
Diagnosis and 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 $200,000 per member per lifetime combined In- and Out-of-network	

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Refer to the Subscriber Agreement for a more complete description of benefits.

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

EXCLUSIONS FOR CLASSIC without Dental (IIP10182):

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

- **Alcoholism and Substance Abuse services** except for substance abuse detoxification services.
- **Alternative/complementary therapies**, except as specified in the *Subscriber Agreement* and only if received through a Participating Provider/Practitioner.
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the *Subscriber Agreement*.
- **Athletic trainers.**
- **Autopsies and/or transportation costs** for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.
- **Benefits and services not specified as Covered**.
- **Biofeedback**.
- **Cancer Clinical Trials** are limited and must be provided for in the state of New Mexico in accordance with provisions as set forth in the *Subscriber Agreement*. Refer to your *Subscriber Agreement* for details.
- **Care for conditions which state or local law requires be treated** in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled and for which facilities are reasonably available to the Member.
- **Charges above Reasonable and Customary charges**.
- **Charges that are determined to be unreasonable by PIC**.
- **Circumcisions** performed other than during the newborn's Hospital stay, unless Medically Necessary.
- **Clothing or other protective devices** including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not.
- **Co-dependency** treatment.
- **Convenience items.**
- **Cosmetic Surgery, treatments**, **devices, orthotics, and medications**, including treatment of hair loss.
- **Costs for extended warranties** and premiums for other insurance coverage.
- **Counseling –** sex, pastoral/spiritual and bereavement counseling.
- **Court-ordered evaluation or treatment**, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.
- **Custodial or domiciliary care**.
- **Dental care** and dental X-rays, except as provided in the Subscriber Agreement.
- **Dental implants**
- **Disposable medical supplies**, except when provided in a Hospital or Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics:** Additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to normal wear, loss, neglect, theft, misuse, abuse, to improve appearance, or for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Elective abortions**.
- **Emergency facility** used for non-emergent services.
- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction.
- **Experimental or investigational**, as determined by PIC; including drugs, medicines, treatments, or procedures.
- **Extracorporeal shock wave therapy.**
- **Eye movement therapy**.
- **Eye refractive procedures** including redial keratotomy, laser procedures, and other techniques.

EXCLUSIONS FOR CLASSIC without Dental (IIP10182):

- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the *Subscriber Agreement* and only when received through Participating Providers/Practitioners.
- **Foot care (routine)**, except as provided in the *Subscriber Agreement*.
- **Foot orthotics** functional and/or customized except as described in the *Subscriber Agreement***.**
- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses**.
- **Hearing aids** and the evaluation for the fitting of hearing aids **except for school aged children under 18 years old (or under 21 years of age if still attending high school)**
- **Hospice benefits are not covered for the following services**: food, housing, and delivered meals, volunteer services, 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; or bereavement counseling.
- **Hospital, physician, mid-wife** and other charges related to prenatal care and delivery of a newborn except as described in the Subscriber Agreement.
- **Hypnotherapy**.
- **Infant formula**.
- **Infertility treatment/Artificial conception and drugs**.
- **In-vitro, GIFT and ZIFT fertilization**.
- **Malocclusion treatment**, if part of routine dental care and orthodontics.
- **Massage therapy**, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program.
- **Maternity/Obstetrical care** including, but not limited to, any condition which is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and postnatal care, except as described in the *Subscriber Agreement*.
- **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Member or when the transplant procedure is not Covered.
- **Mental Health Services including medications.**
- **New medications** for which the determination of criteria for Coverage has not yet been established by PIC's Pharmacy and Therapeutics Committee.
- **Nutritional supplements,** unless as sole source of nutrition.
- **Organ transplants (Non-human),** except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures**.
- **Orthodontic appliances and orthodontic treatment** (braces), crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Over-the-counter medications** except as specified in the *Subscriber Agreement (SA).*
- **Personal or comfort items, services or treatments**.
- **Photopheresis** for all conditions other than mycosis fungoides.
- **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, travel, passports or functional capacity examinations related to employment.
- **Prescriptions** purchased at a non-Participating Pharmacy, unless due to an emergency occurring out side of the PIC Service Area**.**
- **Prescription Drug** replacements due to loss, theft or destruction.

EXCLUSIONS FOR CLASSIC without Dental (IIP10182):

- **Prescription Drugs** (as listed as Covered in this *Schedule of Benefits* or the Optional Prescription Drug Rider and the *Subscriber Agreement*) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating Outpatient Pharmacy is not available.
- **Prescription Drugs –** compounded medications.
- **Prescription Drugs requiring a Benefit Certification when Certification was not obtained**.
- **Private-duty nursing.**
- **Psychological** testing.
- **Residential Treatment Centers.**
- **Reversals of voluntary sterilization**.
- **Services for which the Member is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member.
- **Services requiring Benefit Certification** when Certification was not obtained.
- **Services, other than emergent or urgent in nature,** received outside of the **United States.**
- **Sex transformation surgery and drugs related to sex transformations.**.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics except for penile prosthesis as provided in the *Subscriber Agreement*.
- **Sleep Studies.**
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or behavioral or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances, except as Covered under the Family, Infant and Toddler (FIT) program.
- **Special Medical Foods,** except as listed as Covered in the *Subscriber Agreement* for Genetic Inborn Errors of Metabolism.
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- "**Telephone visits** and electronic mail (e-mail)" by Physician or "consultation" by telephone for which a charge is made to the patient except for members that have been diagnosed with diabetes.
- **Transportation costs** for deceased Members.
- **Travel and lodging** expenses, except as provided in the *Subscriber Agreement.*
- **Vision Care (routine) and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the *Subscriber*.
- **Visual training**.
- **Vocational Rehabilitation services and Long-Term Rehabilitation services**.
- **Weight reduction or control treatments and medications**, except for Medially Necessary treatment for morbid obesity.
- **Work-related accidents** or injuries or occupational illness or disease if the Member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists.

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

Plan IDs – IIP10251 (for internal use only)

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

Presbyterian Insurance Company
P.O. Box 26267
Albuquerque, NM 87125-6267

www.phs.org

Presbyterian Customer Service Center
(505) 923-6980
1-800-923-6980
TTY/TDD (505) 923-5699
TTY/TDD toll-free 1-877-298-7407