CHOICE CARE 15/250
SMALL GROUP
POS
(HHG10002)

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by Presbyterian Health Plan (PHP). Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to Sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	LIMITS	
	In-Network Copayment	**Out-of-Network Copayment[3]**
ANNUAL CALENDAR YEAR DEDUCTIBLE - In-Network Copayments, Prescription Drug Copayments, amounts in excess of Reasonable and Customary Charges and additional charges incurred as a result of failure to obtain Benefit Certification are **not** counted towards the Deductible.	None	$750 per Individual Family: 3x Individual
ANNUAL OUT-OF-POCKET MAXIMUM	2x Annual Premium Does **not** include, Prescription Drug Copayments, charges over Reasonable and Customary or non-covered charges including charges incurred after the benefit maximum has been reached.	Individual: $2,500 Family: 3x Individual Includes % Copayments only – Does **not** include Deductible, penalty amounts, charges above Reasonable and Customary, Prescription Drug Copayments, or non-covered charges including charges incurred after the benefit maximum has been reached.
SPECIALTY PHARMACEUTICAL ANNUAL CALENDAR YEAR OUT-OF POCKET MAXIMUM	$1,500 per Calendar Year	**Not Covered**
MAXIMUM LIFETIME BENEFIT	Unlimited	
BENEFITS AND COVERAGE	**In-Network Copayment**	**Out-of-Network Copayment[3]**
PHYSICIAN SERVICES including:		
Office visits		
• Primary Care Physician (PCP)	$15 Copayment per visit	50%
• Specialist	$15 Copayment per visit	50%
Home visits if Medically Necessary	$25 Copayment per visit	50%
Outpatient Surgery (In Physician's office)	Included in office visit Copayment	50%
Specialty Pharmaceuticals[1] (Injectable forms administered in Physician's office)	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year	**Not Covered**
Allergy Services		
• Testing	20% Copayment	60%
• Serum (extracts)	20% Copayment	60%
• Injections	Included in office visit Copayment (waived if nursing visit only)	50%

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

CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
PHYSICIAN SERVICES *continued from previous page*		
Injections such as insulin, heparin and injectable antibiotics	Included in office visit Copayment (waived if nursing visit only)	50%
Infertility Services including drugs and injections[1]	50% Copayment	**Not Covered**
On-campus Student Health Center	$15 Copayment per visit	$15 Copayment per visit[2] Not Subject to Reasonable and Customary
Hospital and Skilled Nursing Care visits	$0 Copayment	50%
HOSPITAL SERVICES – Inpatient[1] Coverage Includes: • Room and Board • Newborn delivery and other Hospital Obstetrical services • In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services • Detoxification	$250 Copayment per admission	50%[4]
MEDICAL SERVICES – Outpatient		
• Surgeries[1] (at facility)	$100 Copayment per visit	50%[4]
• X-ray and laboratory tests	$0 Copayment	50%
• PET[1]/CAT Scans	$0 Copayment	50%[4]
• Cardiac Cath/ GI Lab	$0 Copayment	50%
• Radiation Therapy (Non-surgical)	$0 Copayment	50%
• Chemotherapy	$0 Copayment	50%
Specialty Pharmaceuticals[1] Oral or inhalation forms/ Self-administered	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year	**Not Covered**
Specialty Pharmaceuticals[1] Intravenous (IV)	$0 Copayment	**Not Covered**
• Magnetic Resonance Imaging (MRI) tests	$50 Copayment per visit	50%[4]
• Sleep Studies	$50 Copayment per study	50%[4]
• Administration of blood/blood components	$0 Copayment	50%

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

CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
RECONSTRUCTIVE SURGERY[1]	Included in Hospital Services – Inpatient, Medical Services – Outpatient, and Physician Services	50%[4]
EMERGENCY ROOM CARE Including trauma services	$50 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies)	$50 Copayment per visit[2] (waived if admitted into a Hospital, then Hospital Copayment applies) – Not subject to Reasonable and Customary Charges
URGENT CARE		
• Participating Provider/Practitioner	$15 Copayment per visit	NA
• Non-Participating Provider/ Practitioner (In or out of the Service Area)	NA	$15 Copayment per visit[2] – Not subject to Reasonable and Customary Charges.
AMBULANCE SERVICES including:		
Emergency or high-risk		
• Ground ambulance	$50 Copayment per occurrence	$50 Copayment per occurrence[2]
• Air ambulance	$100 Copayment per occurrence	$100 Copayment per occurrence[2]
Inter-Facility transfer services		
• Ground ambulance	$0 Copayment [per occurrence	$0 Copayment [per occurrence [2]
• Air ambulance	$100 Copayment per occurrence	$100 Copayment per occurrence[2]
CLINICAL PREVENTIVE SERVICES		
Well Child Care including vision and hearing screening	$15 Copayment per visit	**Not Covered**
Preventive physical exam	$15 Copayment per visit	**Not Covered**
Adult and child immunizations	Included in office visit Copayment (waived if nursing visit only)	**Not Covered**
Office Based Health education	Included in office visit Copayment	**Not Covered**
Family planning services	Included in office visit Copayment	**Not Covered**

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

CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
CLINICAL PREVENTIVE SERVICES *continued from previous page*		
Cytologic Screening (Pap smear)	Included in office visit Copayment	**Not Covered**
Mammography	Included in office visit Copayment	**Not Covered**
Human Papillomavirus (HPV) Screening	Included in office visit Copayment	**Not Covered**
Health Education	Included in office visit Copayment	**Not Covered**
WOMEN'S HEALTH CARE		
Gynecological Care	$15 Copayment per visit	50%
In office Obstetrical/Maternity Care/Prenatal & Postnatal care	$15 Copayment per visit up to a maximum of $150 per pregnancy	50%
Specialist (i.e. Perinatologist)	$15 Copayment per visit Not included in $150 maximum listed above	50%
Cytologic (Pap Smear), Human Papillomavirus (HPV) screening, and Mammograms refer to Clinical Preventive Services.		
Newborn Delivery and other Hospital Obstetrical Services	$250 Copayment per admission	50%
Implantable contraceptive devices		
• Insertion	50% Copayment per insertion	**Not Covered**
• Removal	Included in office visit Copayment	**Not Covered**
DIABETES SERVICES		
Office visit and Diabetes education	Included in office visit Copayment	**Not Covered**
Diabetic supplies[1] (Purchased through a Participating Durable Medical Equipment Supplier)	50% Copayment	**Not Covered**
Diabetic supplies including Insulin and diabetic oral agents for controlling blood sugar (Purchased through a Participating Pharmacy)	Generic (Preferred) - $7 Copayment Brand (Preferred) - $17 Copayment Non-Preferred – $37 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**

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CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
COVERED MEDICATIONS – Outpatient (Purchased at a Participating Pharmacy, unless due to an emergency occurring outside of the PHP Service Area)		
• Medically Necessary Nutritional Supplements for prenatal care • Insulin and diabetic oral agents • Diabetic supplies (purchased through a Participating Pharmacy) • Smoking cessation drugs (Limited to 2 90-day courses of treatment per Calendar Year)	Generic (Preferred) - $7 Copayment Brand (Preferred) - $17 Copayment Non-Preferred – $37 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer).	**Not Covered**
Immunosuppressive drugs following transplant surgery		
• Oral	Generic (Preferred) - $7 Copayment Brand (Preferred) - $17 Copayment Non-Preferred – $37 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Injectable	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year	**Not Covered**
Specialty Pharmaceuticals[1] Oral or inhalation forms/ Self-administered	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year	**Not Covered**
Specialty Pharmaceuticals[1] Intravenous (IV)	$0 Copayment	**Not Covered**
Special Medical Foods[1]	50% Copayment	**Not Covered**

For plans with "Covered Medications" coverage only this plan is considered Non-Creditable per Medicare part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.

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CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
PRESCRIPTION DRUGS (RETAIL)		
• Generic (Preferred)	$7 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (Preferred)	$17 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (when a generic equivalent is available)	Generic Copayment plus the difference in the cost of the brand and generic (per 30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Non-Preferred	$37 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Pre-packaged items	Applicable Copayment (generic, brand, Non-Preferred) per pre-packaged item	**Not Covered**
PRESCRIPTION DRUGS (MAIL ORDER)		
• Generic (Preferred)	2 x generic Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (Preferred)	2.5 x generic Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (when a generic equivalent is available)	2 x brand Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Non-Preferred	3 x generic Copayment plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Pre-packaged items	Applicable mail order Copayment (generic, brand, Non-Preferred) per pre-packaged item	**Not Covered**

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CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
MENTAL HEALTH SERVICES[1]		
Outpatient	$15 Copayment per visit	50% [4]
Inpatient	$250 Copayment per admission	50%[4]
Partial Hospitalization	$250 Copayment per admission (waived if immediately following an Inpatient hospitalization discharge)	50%[4]
ALCOHOL AND SUBSTANCE ABUSE SERVICES[1]		
Detoxification		
• Outpatient	$15 Copayment per visit	50%[4]
• Inpatient	$250 Copayment per admission	50%[4]
Rehabilitation		
Outpatient - up to 30 visits per Calendar Year	**Not Covered**	**Not Covered**
Inpatient or partial hospitalization – up to 30 days per Calendar Year	**Not Covered**	**Not Covered**
Combined Inpatient and Outpatient services are limited to 1 episode of treatment per Calendar Year, 3 episodes per lifetime		
REHABILITATION AND THERAPY SERVICES		
Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year)	$15 Copayment per session	**Not Covered**
Dialysis/Plasmapheresis/ Photophoresis	20% Copayment per visit	50%[4]
Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)	$15 Copayment per session	**Not Covered**
Short-term Rehabilitation[1] (Physical and Occupational Therapy up to 2 months per condition)		

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CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
REHABILITATION AND THERAPY SERVICES *continued from previous page*		
• Inpatient	$250 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Hospice, or Skilled Nursing Facility)	50%[4]
• Outpatient	$25 Copayment per session	50%[4]
Speech[1] and Hearing Therapy[1] (up to 2 months per condition)	$25 Copayment per session	50%[4]
TRANSPLANTS[1]	$250 Copayment per admission	**Not Covered**
COMPLEMENTARY THERAPIES (Limited)		
Acupuncture Services (up to 20 visits per Calendar Year if Medically Necessary as specified in Section IV. Item E of the Group Subscriber Agreement)	$25 Copayment per session	**Not Covered**
Chiropractic Services (up to 18 visits per Calendar Year if Medically Necessary)	$25 Copayment per session	**Not Covered**
Biofeedback for specific conditions	$15 Copayment per session	**Not Covered**
SKILLED NURSING FACILITY[1] (Up to 60 days per Calendar Year)	$250 Copayment per admission (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Hospice facility)	50%[4]
HOME HEALTH CARE SERVICES[1]**/ HOME INTRAVENOUS SERVICES**[1]		
Services provided by an RN, LPN and other specified specialist	$0 Copayment	50%[4]
Home intravenous services and supplies	$0 Copayment	50%[4]
Specialty Pharmaceuticals[1] – Oral or inhalation forms/ Self-administered	15% Copayment up to a maximum of $250 per injection and $1,500 per Calendar Year	**Not Covered**
Specialty Pharmaceuticals[1] Intravenous (IV)	$0 Copayment	**Not Covered**

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CHOICE CARE 15/250 SMALL GROUP HHG10002 BENEFITS AND COVERAGE	In-Network Copayment	Out-of-Network Copayment[3]
HOSPICE CARE[1] Inpatient In-home	$250 Copayment per admission (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Skilled Nursing Facility) $0 Copayment	50%[4] 50%[4]
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[1]	50% Copayment	**Not Covered**
EYEGLASSES AND CONTACT LENSES[1] Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus, or when related to Genetic Inborn Errors of Metabolism • Refraction eye exam associated with post cataract surgery or Keratoconus correction	50% Copayment Included in office visit Copayment	**Not Covered** **Not Covered**
DENTAL SERVICES/(CMJ/TMJ) (Limited)	Included in office visit Copayment	50%
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 Copayment $3,500 per Member per Calendar Year Maximum benefit Not applicable to any Lifetime Maximums or annual limits	

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EXCLUSIONS FOR CHOICE CARE 15/250 SMALL GROUP (HHG10002):

Refer to the Group Subscriber Agreement for a more complete description of Exclusions & Limitations.
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 Care Services. Refer to your Group Subscriber Agreement for details.

- **Alcoholism and Substance Abuse services**, except for Substance Abuse Medical Detoxification services.
- **Alternative/complementary therapies,** except as specified in the Group Subscriber Agreement (GSA).
- **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 Group Subscriber Agreement (GSA).
- **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**, except as specified in the Group Subscriber Agreement (GSA).
- **Cancer Clinical Trials** are limited to phase 2, 3 and 4 and must be provided for in the State of New Mexico in **accordance with the provisions set forth in the Group Subscriber Agreement (GSA).**
- **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 that are determined to be unreasonable by PHP.**
- **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 items 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 Group Subscriber Agreement (GSA).
- **Dental implants**.
- **Disposable medical supplies**, except when provided in a Hospital or a Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics** except as listed as Covered in this Schedule of Benefits and the Group Subscriber Agreement – additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Elective abortions** after the 24th week of pregnancy.
- **Elective Home Birth** and any prenatal or postpartum services connected with an Elective Home Birth.
- **Emergency facility** used for non-emergent services.
- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.
- **Experimental/Investigational,** as determined by PHP, drugs, medicines, treatments or procedures.

EXCLUSIONS FOR CHOICE CARE 15/250 SMALL GROUP (HHG10002):

- **Extracorporeal shock wave therapy** involving the musculoskeletal system.
- **Eye movement therapy.**
- **Eye refractive procedures** including radial keratotomy, laser procedures, and other techniques.
- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Group Subscriber Agreement (GSA).
- **Foot care (routine)**, except as provided in the Group Subscriber Agreement (GSA).
- **"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.
- **Home Sleep Studies.**
- **Hospice benefits are not available 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.
- **Hypnotherapy** except as part of anesthesia preparation or chronic pain management.
- **Infant formula.**
- **In-vitro, GIFT and ZIFT fertilization.**
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife.
- **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.
- **Medical and Hospital services of a donor** when the recipient of an Organ transplant is a not a Member or when the transplant procedure is **not Covered**.
- **New medications** for which the determination of criteria for Coverage has not yet been established by PHP's Pharmacy and Therapeutics Committee.
- **Nutritional supplements** except as provided in the Group Subscriber Agreement (GSA).
- **Organ transplants (Non-human),** except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures.**
- **Orthodontic appliances** and orthodontic treatment, 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.
- **Orthotics (functional foot),** except as provided in the Group Subscriber Agreement (GSA) for patients with diabetes or other significant peripheral neuropathies.
- **Orthotics/orthosis (Custom Fabricated)** except as specified in the Groups Subscriber Agreement (GSA).
- **Out-of Network services** for Acupuncture, Cancer Clinical Trials, Cardiac and Pulmonary Rehabilitation, Clinical Preventive Services, Chiropractic, Covered Medications, Diabetes Services, Diagnosis and Treatment of Infertility, Durable Medical Equipment, Prescription Drugs filled at a Non-Participating Pharmacy, Smoking Cessation Services and Treatment, Specialty Pharmaceuticals and Transplants.
- **Over-The-Counter (OTC) medications** except as specified in the Group Subscriber Agreement (GSA).
- **Personal or comfort items, services or treatments.**
- **Photophoresis** for all conditions other than mycosis fungoides.

EXCLUSIONS FOR CHOICE CARE 15/250 SMALL GROUP (HHG10002):

- **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.
- **Prescription Drugs** (as listed as Covered in this Schedule of Benefits, and the Group Subscriber Agreement) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.
- **Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained**.
- **Prescription Drugs ordered by a Non-Participating Provider** or purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area.
- **Prescription Drug,** compounded medications.
- **Prescription Drug replacements** due to loss, theft, or destruction.
- **Private duty nursing.**
- **Psychological testing** when not Medically Necessary.
- **Residential Treatment Centers** unless for the treatment of Alcoholism and/or Substance Abuse rehabilitation and **only** when Alcohol/Substance Abuse Rehabilitation Services are Covered.
- **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 or Dependent.
- **Services requiring Benefits Certification** when Benefit Certification was not obtained.
- **Sex transformation surgery and drugs** relating to sex transformation.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics, except for penile prosthesis as provided in the Group Subscriber Agreement (GSA).
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the Group Subscriber Agreement (GSA) for more information.
- **Special Medical Foods,** except as listed as Covered in the Group Subscriber Agreement (GSA) 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 a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient.
- **Transportation costs** for deceased Members.
- **Travel and lodging** expense, except as provided in the Group Subscriber Agreement (GSA).
- **Vision care (routine) and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the Group Subscriber Agreement (GSA).
- **Visual training.**
- **Vocational Rehabilitation services and Long-Term Rehabilitation services.**
- **Weight reduction or control treatments and medications**, except for Medically 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 Group Subscriber Agreement for a more complete description of Exclusions & Limitations.

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.

PLAN ID'S – HHG10002

Billing Example:

Choosing a provider can impact the amount you pay for covered services.

When selecting a provider you have the choice between a Network Provider (this is a provider that has a contract with your health care plan and will provide services for set amount that the plan and provider have agreed on, this is referred to as reasonable and customary charges) and an Out of Network provider (this is a provider that does not have a contract with your health care plan and can set there own prices of services that are being rendered).

The amount that your plan is going to pay is based on 80% of the R&C charges "reasonable and customary". You or your coinsurance will be responsible for covering the remaining 20%.

Below you will find two examples:
Example one is In Network claim payment and advantages over Our of Network

Example two is an out of network claim payment and disadvantages of choosing an Out of Network provider.

Example 1. In-Network Provider Claim Payment (80% Plan; Deductible is met)	
Provider's billed charge	$10,000.00
R&C charges (maximum amount that can be considered for benefit payment)	$ 8,000.00
The Health Care Plans payment to provider (80% of $8,000.00)	$ 6,400.00
Member coinsurance (20% of $ 8,000.00) applied to out-of-pocket limit	- $ 1,600.00
Amount over the R&C charges, the consumer is responsible for all cost incurred over the R&C charges these amounts do not apply to your out of pocket limits)	- $ 0.00
With coinsurance: the total amount due would be:	**$ 0.00**
Total amount due without coinsurance:	**$ 1,600.00**

Example 2. Out-of-Network Provider Claim Payment (80% Plan; Deductible is met)	
Provider's billed charge	$10,000.00
R & C charges (maximum amount that can be considered for benefit payment)	$ 8,000.00
The Health Care Plans payment to provider (80% of $8,000.00)	$ 6,400.00
Member coinsurance (20% of $ 8,000.00) applied to out-of-pocket limit	- $ 1,600.00
Amount over the R&C charges, the coinsurance is responsible for all cost incurred over the R&C charges these amounts do not apply to your out of pocket limits)	$ 2,000.00
With coinsurance: the total amount due would be:	**$ 2,000.00**
Total amount due without coinsurance:	**$ 3,600.00**

Example 3	In-Network Hospital (Plan Pays 90%)	Out-of-Network Hospital (Plan Plays 70%)
Actual Hospital Charge	$10,500	$10,500
Amount Recognized by medical plan:	$6,500 (the discounted rate for health plan)	$8,800 (Reasonable and Customary charges based on standard charges for that geographic area) Plan does not recognize the $1,700 difference between the actual charge and the R&C
Medical plan pays:	90% of the discounted rate: $6,500 x 90% = $5,950	70% of the discounted rate: $8,800 x 70% = $6,160
Member pays:	10% of the discounted rate: $6,500 x 10% = $650	30% of R&C charges ($8,800) plus 100% of the amount over R&C ($1,700): $2,640 + $1,700 = $4,340

Presbyterian Disclaimer: This information is being provided to you in accordance with NM Regulation 13.10.13.8(C) (13) (Patient Rights and Responsibilities) and may not fully reflect your actual billing experience. These examples are provided to illustrate the difference in obtaining services from an In-network Provider versus an Out-of-network Provider. If you have any questions in regards to your billing please contact our Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407.

PRESBYTERIAN

Offered by Presbyterian Health Plan

PHP Flex/Choice Care POS Plans (2007)
PHP My Care Independent Plan (2007)

ENDORSEMENT REGARDING - 2007 Commercial Benefit Mandates

Effective 6/15/07

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement and/or Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

Section IV. Benefits, item D. Clinical Preventive Services, and item I. Durable Medical Equipment of the Group Subscriber Agreement – The following language regarding *Hearing Aids* has been amended and will now read as follows:

D. Clinical Preventive Services

3. Vision and Hearing Screening performed only by the PCP to determine the need for vision and hearing correction. This does not include routine eye exams or Eye Refractions performed by eye care specialists. One Eye Refraction per Calendar Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases. **Hearing aids and the evaluation for the fitting of hearing aids is not Covered except for school aged children under 18 years old (or under 21 years of age if still attending high school).**

I. 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.

7. Hearing Aids

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):**

a. Up to $2,200 every 36 months "per hearing impaired ear" for school aged children under 18 years old (or under 21 years of age if still attending high school).

b. Shall include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by a Participating Provider/Practitioner licensed in New Mexico.

Section IV. Benefits, item V. Rehabilitation and Therapy of the Group Subscriber Agreement – The following language regarding *Hearing Aids* has been amended and will now read as follows:

V. Rehabilitation and Therapy

4. Outpatient Speech Therapy**.**

g. Hearing aid evaluations are **not Covered except for school aged children under 18 years old (or under 21 years of age if still attending high school)**.

Section VII. Exclusions, item AH. Hearing Aids of the Group Subscriber Agreement – The following language regarding *Hearing Aids* has been amended and will now read as follows:

VII. Exclusions:

AH. **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)**.

Section XVII. Glossary of the Group Subscriber Agreement – The following definition has been added regarding *Hearing Aids*:

HEARING AID means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

The following language located in the Schedule of Benefits regarding Hearing Aids has been added and will read as follows:

	In-Network and Out-of-Network Copayment
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[1] • **Hearing Aids (for school aged children under age 18 or 21 years of age if still attending high school)**	**Refer to Schedule of Benefits for Copayment Amounts.** **Up to $2,200 every 36 months "per hearing impaired ear".**

The following language located in the Exclusions section of the Schedule of Benefits regarding *Hearing Aids* has been amended and will read as follows:

- **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)**.

Section IV. Benefits, item D. Clinical Preventive Services of the Group Subscriber Agreement – The following language regarding *Colorectal Cancer Screenings* has been amended and will now read as follows:

D. Clinical Preventive Services

5. Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:

   a. Fecal occult blood testing (FOBT),

   b. Flexible Sigmoidoscopy,

   c. Colonoscopy,

   d. Double contrast barium enema.

Section IV. Benefits, item D. Clinical Preventive Services and item Z. Women's Healthcare of the Group Subscriber Agreement – The following language regarding *Coverage of HPV Vaccine* for females aged nine to 14 years of age has been added and will now read as follows:

D. Clinical Preventive Services

11. HPV Vaccine Coverage for the Human Papillomavirus, as approved by the Food and Drug Administration, for females nine to 14 years of age used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations ***in accordance with guidelines established by*** The Advisory Committee on Immunization Practices (ACIP).

Z. Women's Healthcare

7. Cytologic Screening (PAP Smear), Human Papillomavirus (HPV) screenings, HPV Vaccine coverage for females nine to 14 years of age and other populations ***in accordance with guidelines established by*** The Committee on Immunization Practices (ACIP), and mammography Coverage described in Section IV. (Benefits) item D. (Clinical Preventive Services).

IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Group Subscriber Agreement/Schedule of Benefits Endorsement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN, INC.

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Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

PRESBYTERIAN HEALTH PLAN INC.

ENDORSEMENT REGARDING Dental Implants
For:
PHP Flex/Choice Care
PHP My Care Independent
POS Plans
Effective 6/1/06

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement or Subscriber Agreement not specifically amended by this Endorsement shall remain in full force and in effect.

Section IV. (Benefits) item F.8 (Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ) has been replaced with the following:

Dental implants are not covered.

IN WITNESS THEREOF, Presbyterian Health Plan, Inc., has caused this Group Subscriber Agreement or Subscriber Agreement Endorsement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN, INC.

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Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

PRESBYTERIAN

Offered by Presbyterian Health Plan

PHP Flex Care/Choice Care POS Plans (2007)
PHP My Care Independent Plan (2007)

ENDORSEMENT REGARDING - 2007 Commercial Benefit Mandate Regarding Health Insurance Coverage for General Anesthesia and Hospitalization for Dental Surgery

Effective 7/1/07

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement and/or Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

Section IV. Benefits, item F. Dental Services of the Subscriber Agreement – The following language regarding *General Anesthesia and Hospitalization for Dental Surgery* has been amended and will now read as follows:

F. Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)

5. **Hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services, are Covered if,** provided in a hospital or ambulatory surgical center for dental surgery when approved by PHP. Plan benefits for these services include coverage:

   a. for Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;

   b. for Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

   c. for Covered children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

   d. for Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; and

   e. for *other procedures* for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.

Section VII. Exclusions, item X.1. Dental care of the Subscriber Agreement – The following language regarding *General Anesthesia and Hospitalization for Dental Surgery* has been amended and will now read as follows:

VII. Exclusions relating to Dental Services:

X.1 **Dental care and** dental x-rays, except as provided in Section IV. (Benefits) item F. (Dental Services/TMJ/CMJ), hospitalization, day surgery, outpatient services and/or anesthesia for Non-Covered dental services **are covered if provided in a hospital or ambulatory surgical center for dental surgery when approved by PHP.**

IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Group Subscriber Agreement/Schedule of Benefits Endorsement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN, INC.

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Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

PRESBYTERIAN HEALTH PLAN INC.

Choice Care/Flex Care
POS

ENDORSEMENT REGARDING WEB VISITS

Effective 05/01/07

All terms, benefits, exclusions and provisions of the Schedule of Benefits and Group Subscriber Agreement not specifically amended by this Endorsement shall remain in full force and in effect.

For the Choice Care/Flex Care, under the Schedule of Benefits, the subsection "Physician Services" has added the following:

	In –Network Copayment	Out-of-Network Copayment
Web Visits ***Provided through PHP contracted Web Visits Providers as identified in the Provider Directory.***		
• **Primary Care Physician (PCP)**	**$5 Copayment per visit**	**Not Covered**
• **Specialist**	**$5 Copayment per visit**	**Not Covered**

For the Choice Care/Flex Care, under the Schedule of Benefits, the subsections "Clinical Preventive Services" and "Women's Health Care" have added the following:

	In –Network Copayment	Out-of-Network Copayment
Web Visits ***Provided through PHP contracted Web Visits Providers as identified in the Provider Directory.***	**$5 Copayment per visit**	**Not Covered**

Throughout the Group Subscriber Agreement and Schedule of Benefits, the exclusion for "electronic mail (E-mail)" has been removed. "Electronic mail (E-mail)" is a Covered benefit.

Section XVIII. Glossary of Terms, under the Group Subscriber Agreement;
The following definition has been added:

WEB VISITS means an online consultation between a doctor and an established patient about a non-urgent healthcare matter.

IN WITNESS THEREOF, Presbyterian Health Plan, Inc., has caused this Schedule of Benefits and Group Subscriber Agreement Endorsement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN, INC.

Lisa Farrell
Vice President & Chief Financial Officer
Presbyterian Health Plan, Inc.

PRESBYTERIAN

Offered by Presbyterian Health Plan

PHP Custom/Value Care Plans
PHP My Care Plans
PHP Smart Care Plans
PHP Flex/Choice Care Plans
PHP Alliance Group and Individual Plans
PHP Minimum Health Care Protection Plan
PHP Conversion Plan

ENDORSEMENT REGARDING Benefit Certification or Preauthorization Requirement for MRI/CAT Scans

Effective 12/15/08

All terms, benefits, exclusions and provisions of the Group Subscriber Agreement and Schedule of Benefits not specifically amended by this Endorsement shall remain in full force and in effect.

Section V. (Benefit Certification/Preauthorization), item C. (What Services and Supplies Require Benefit Certification), of the Subscriber Agreement – Computed Axial Tomography (CAT) scans and Magnetic Resonance Imaging (MRI) tests have been added to the list requiring Benefit Certification and will be listed as follows:

C. What Services and Supplies Require Benefit Certification or Preauthorization?

Computed Axial Tomography (CAT) Scans;
Magnetic Resonance Imaging (MRI) tests;

The following language located in the Schedule of Benefits has been amended to read as follows:

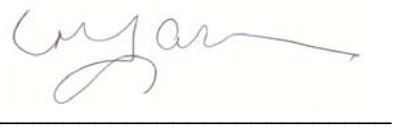
MEDICAL SERVICES – Outpatient
• **PET[(1)]/CAT[(1)] Scans**

• **Magnetic Resonance Imaging (MRI)[(1)] tests**

[(1)] Benefit Certification or Pre-authorization may be required

IN WITNESS THEREOF, Presbyterian Health Plan, Inc. has caused this Subscriber Agreement Endorsement to be executed by a duly-authorized agent.

PRESBYTERIAN HEALTH PLAN, INC.



Lisa Farrell
Treasurer
Presbyterian Health Plan, Inc.

PRESBYTERIAN

Offered by Presbyterian Health Plan

PHP Custom/Value Care Plans
PHP My Care Plans
PHP Smart Care Plans
PHP Flex/Choice Care Plans
PHP Alliance Group Plan
PHP Minimum Health Care Protection Plan

ENDORSEMENT REGARDING –Children's Health Insurance Program Reauthorization Act (CHIPRA) Special Enrollment

Effective April 1, 2009

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* and/or *Schedule of Benefits* not specifically amended by this *Endorsement* shall remain in full force and in effect.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Enrollment
The following changes were made to your *Group Subscriber Agreement*:

In the *Eligibility, Enrollment and Effective Dates* Section, under "Special Enrollment" the following has been added:

3. CHIPRA (in accordance with provisions as currently may be defined under federal law)

   a. An employee, who chose not to enroll in PHP for self and/or dependent(s) during a previous enrollment period because they were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, may request coverage for self and/or any affected eligible Dependent(s) if the Dependent is eligible and was not enrolled within 60 days of the date Medicaid or CHIP coverage terminated.

   b. An employee, who chose not to enroll in PHP for self and/or dependent(s) during a previous enrollment period and has become eligible for group health premium assistance under State Medicaid or State CHIP, may request coverage for self and/or eligible Dependent(s) if the Dependent is eligible and was not enrolled within 60 days of becoming eligible.

   c. If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the employee is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later then the first day of the month following receipt of your enrollment request.

IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* and/or *Schedule of Benefits* Endorsement to be executed by a duly-authorized agent.

PRESBYTERIAN HEALTH PLAN

Lisa Farrell
Treasurer
Presbyterian Health Plan

PRESBYTERIAN

Offered by Presbyterian Health Plan

PHP Conversion Plan
PHP Custom/Value Care Plans
PHP My Care Plans
PHP Smart Care Plans
PHP Flex/Choice Care Plans
PHP Alliance Group and Individual Plans

ENDORSEMENT REGARDING – Cancer Clinical Trials Benefit Enhancements

Effective July 1, 2009

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* and/or *Schedule of Benefits* not specifically amended by this *Endorsement* shall remain in full force and in effect.

Coverage for Cancer Clinical Trials will follow the guidance set forth in Senate Bill 24. As such, the following changes are made to your Group Subscriber Agreement:

A. Where "Cancer Clinical Trials" is listed in the Benefits section, the Limitations and Exclusions section, and the Glossary delete the words "phase I, II, III or IV."

B. Also, in the Benefits section and Glossary, the definition of Cancer Clinical Trials, "routine costs" now reads as follows:

   Routine patient care costs are Covered for Members in a Cancer Clinical Trial if:

   a. The Cancer Clinical Trial is undertaken for the purposes of the **prevention of or** the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists.

   b. The Cancer Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.

   c. The Cancer Clinical Trial is being provided **in New Mexico** as part of a scientific study of a new therapy or intervention.

   d. There is not a non-Investigational treatment equivalent to the Cancer Clinical Trial.

   e. There is a reasonable expectation shown in clinical or pre-clinical data that the Cancer Clinical Trial will be at least as efficacious as any non-Investigational alternative.

   f. There is a reasonable expectation based on clinical data that the medical treatment provided in the Cancer Clinical Trial will be at least as effective as any other medical treatment.

   g. Pursuant to the patient informed consent, Presbyterian is not liable for damages associated with the treatment provided during any phase of a Cancer Clinical Trail.

IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* and/or *Schedule of Benefits* Endorsement to be executed by a duly-authorized agent.

PRESBYTERIAN HEALTH PLAN

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Lisa Farrell
Treasurer
Presbyterian Health Plan

PRESBYTERIAN

Offered by Presbyterian Health Plan

PHP Flex/Choice Care Plans
(HHG10002, HHG10005)

ENDORSEMENT REGARDING – Autism Spectrum Disorder Diagnosis and Treatment Benefit

Effective July 1, 2009

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* and/or *Schedule of Benefits* not specifically amended by this *Endorsement* shall remain in full force and in effect.

Coverage for Autism Spectrum Disorder Diagnosis and Treatment in accordance with Senate Bill 39. As such, the following changes are made to the respective *Schedules of Benefits* and *Group Subscriber Agreements*:

A. Under the Benefits section, the following is added:

   Autism Spectrum Disorder

   The diagnosis and treatment for Autism Spectrum Disorder is covered for children, from birth to age nineteen (19) (or up to age twenty-two (22) if enrolled in high school) in accordance with state mandates (Senate Bill 39) as follows:

   1. Diagnosis for the presence of Autism Spectrum Disorder when performed during a well child or well baby screening; and/or
   2. Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

   These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health Services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with Senate Bill 39 and current Presbyterian Health Plan (PHP) guidelines.

   Autism Spectrum Disorder Services must be provided by Providers/Practitioners who are certified, registered or licensed to provide these services. Applied Behavioral Analysis (ABA) and other Autism Spectrum Disorder services may require Benefit Certification prior to being provided. If Benefit Certification is not obtained when required, the claim may be denied or the benefits reduced as listed on the *Schedule of Benefits*.

   Limitation – services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three (3) to twenty-two (22) years of age who have Autism Spectrum Disorder are not covered under this Plan.

B. Under Benefits, Rehabilitation and Therapy, Long Term Therapy, delete the word "autism" in the second sentence.

C. Under the Glossary, please add the following:
Autism Spectrum Disorder – means a condition that meets the diagnostic criteria for the pervasive development disorders published in the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, including Autistic Disorder; Asperger's disorder; Pervasive Development Disorder not otherwise specified; Rett's Disorder; and Childhood Disintegrative Disorder.

D. The following benefit information is added to the *Schedule of Benefits*:

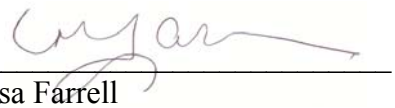
	Limits
Autism Spectrum Disorder Diagnosis and Treatment Maximum Lifetime Benefit	$200,000 per member per lifetime (Does not apply to Plan lifetime maximum.) Beginning January 1, 2011, the maximum benefit shall be adjusted manually on January 1 to reflect any change from the previous year in the medical 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.

Benefits and Coverage	**Copayment**	
	In-network Copayment	**Out-of-Network Copayment(3)**
Autism Spectrum Disorder (1)		
Treatment through or provided by:		
PCP	$15 Copay per visit	50% Copay per visit
Specialist	$15 Copay per visit	50% Copay per visit
Outpatient Physical Therapy	$25 Copay per visit	50% Copay per visit(4)
Outpatient Occupational Therapy	$25 Copay per visit	50% Copay per visit(4)
Outpatient Speech Therapy	$25 Copay per visit	50% Copay per visit(4)
Applied Behavioral Analysis (ABA) (1)	$15 Copay per visit	50% Copay per visit(4)
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 Benefit Certification penalty does not apply towards Calendar Year maximum	

(1) Benefit Certification may be required. (3) Benefits are limited to Reasonable and Customary Charges. You are responsible for any balance due above Reasonable and Customary Charges. (4) 15% penalty applied if Benefit Certification not obtained.

IN WITNESS THEREOF, Presbyterian Health Plan, has caused this *Group Subscriber Agreement* and/or *Schedule of Benefits* Endorsement to be executed by a duly-authorized agent.

PRESBYTERIAN HEALTH PLAN



Lisa Farrell
Treasurer
Presbyterian Health Plan

PRESBYTERIAN

Offered by Presbyterian Health Plan

Alliance Group Plan
Choice/Flex Care Plans
Custom/Value Care Plans
My Care Plans
Smart Care Plans

ENDORSEMENT REGARDING:
Changes to the EFFECT OF OTHER COVERAGE Section

Effective January 1, 2010

All terms, benefits, exclusions and provisions of the *Group Subscriber Agreement* not specifically amended by this Endorsement shall remain in full force and in effect.

In Section X. (Effect of Other Coverage), the "Explanation Box" has been amended and reads as follows:

EFFECT OF OTHER COVERAGE

Some Members may have medical Coverage through other health benefit plans. This Section explains how Presbyterian Health Plan (PHP) coordinates these benefits along with your PHP Coverage.

Item A. (Coordination of Benefits), 2. g. has been added:

g. If a Member is Covered under a motor vehicle or homeowners insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in the Member's own home, the Member shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are Covered by their motor vehicle or homeowners' insurance policy. If such benefits have been provided by PHP, PHP shall have the right to recover any benefits provided from the Member or from the motor vehicle or homeowners' insurance to the extent they are available under the motor vehicle or homeowners' insurance policy.

Item D. Med-Pay (Motor Vehicle, Homeowners Policies) has been deleted.

IN WITNESS THEREOF, Presbyterian Health Plan has caused this *Group Subscriber Agreement* Endorsement to be executed by a duly-authorized agent.

PRESBYTERIAN HEALTH PLAN

Lisa Farrell
Treasurer
Presbyterian Health Plan