PRESBYTERIAN

Offered by Presbyterian Insurance Company, Inc.

PresMetro
PPO Benefit Plans

Service Area	Available in Bernalillo, Sandoval, Torrance, Valencia Counties and Edgewood	
	IIP10138, IIP10145, IIP10152, IIP10159, IIP10166	
MEDICAL Benefits & Coverage	**In-Network**	**Out-of-Network**
Annual Calendar Year Deductible **Individual** (Deductible must be met before payments are made)	IIP10138 = $500 IIP10159 = $2,000 IIP10145 = $750 IIP10166 = $5,000 IIP10152 = $1,000	IIP10138 = $1,000 IIP10159 = $4,000 IIP10145 = $1,500 IIP10166 = $10,000 IIP10152 = $2,000
Family	3x (Individual)	3x (Individual)
Annual Out-of-Pocket Maximum (Does **not** include Deductible)	Individual = $2,000 Family = 3x (Individual)	Individual = $6,000 Family = 3x (Individual)
Lifetime Maximum	$2 million combined in- and out-of-network	
Pre-Existing Limitation (Does not apply to newborns and newly adopted children)	6 months (May be reduced or eliminated with proof of prior Creditable Coverage)	
Unique Service Reimbursement Program (USRP) Such as, but not limited to: Prescription drug costs, routine vision care, dental treatments. Refer to Schedule of Benefits for full listing.	$100 Reimbursement per family per Contract Year	
Physician Services		
Non-Specialist office visit	$20 Copay/visit [2]	50%
Specialist office visit	$20 Copay/visit [2]	50%
Accupuncture and Chiropractic ($1,500/Calendar Year Maximum)	20%	**Not Covered**
Clinical Preventive Services Such as, but not limited to:		
Routine Physicals	Plan Pays	
Adult and Child Immunizations	100%	50%
Well Child Care		
Routine mammogram & Pap screenings		
Preventive Lab, Radiology & Diagnostic Tests		
Diagnostic Tests [1]	20%	50%
Web Visits		
Non-Specialist	$7 Copay/visit [2]	**Not Covered**
Specialist	$7 Copay/visit [2]	**Not Covered**
Hospital [1]		
Inpatient	20%	50%
Outpatient	20%	50%
Durable Medical Equipment, Prosthetics, Appliances [1]	20%	50% ($1,000 per Calendar Year maximum does not apply to supplies for Members with Diabetes)
Transplant Benefit [1] Must use PIC-approved facilities	20%	**Not Covered**
Accidental Injury/Urgent/Emergency Care		
Emergency Care including trauma services	$150 Copay/visit (includes all ER services)	$150 Copay/visit (includes all ER services)
Urgent Care	$30 Copay/visit [2]	$30 Copay/visit [2]

Prescription Drugs [1, 2]	**Standard (Must use Participating Pharmacy)**	**Generic Only (Must use Participating Pharmacy)**	**No Rx**
Generic (Preferred)	$10	Tier 0 = $0 Tier 1 = $10	**Not Covered**
Brand (Preferred)	$35	**Not Covered**	**Not Covered**
Non-Preferred	$75	**Not Covered**	**Not Covered**
Maternity Services	**Not Covered** unless Optional Maternity Benefit Rider has been purchased		

NON-MEDICAL Benefits & Coverage

Dental - Underwritten and Administered by Delta Dental Plan of New Mexico, Inc. Refer to the Schedule of Benefits for details.

Vision - Underwritten and Administered by Vision Service Plan Insurance Company (VSP). Refer to the Schedule of Benefits for details.

[1] Benefit Certification may be required [2] Not subject to Deductible

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

Please refer to the Subscriber Agreement for specific Medical Benefit limitations and exclusions.

EXCLUSIONS FOR PRESBYTERIAN PRESMETRO PPO BENEFIT PLANS: Alcoholism and Substance Abuse services except for substance abuse detoxification services • **Alternative/complementary therapies,** except as specified in the Subscriber Agreement • **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** – certain exclusions apply as identified in the Subscriber Agreement • **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 that are determined to be unreasonable by PIC** • **Circumcisions** except as specified in the Subscriber Agreement • **Clothing** or other protective devices whether by prescription or not • **Co-dependency Treatment** • **Convenience Items** • **Cosmetic Surgery, treatments**, devices, orthotics, and medications including treatment for hair-loss • **Costs for extended warranties** and premiums for other insurance coverage • **Counseling** • **Court ordered evaluation or treatment**, or treatment that is a condition of parole or probation or in lieu of sentencing • **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** - duplicate items, convenience items, upgraded or deluxe items, repair or replacements due to normal wear, loss, neglect, theft, misuse, abuse, to improve appearance, or for convenience or items under the manufacturers 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 programs • **Experimental or investigational**, as determined by PIC, drugs, medicines, treatments, or procedures • **Extracorporeal** shock wave therapy • **Eye movement therapy** • **Eye refractive procedures** including redial keratotomy, laser procedures, and other techniques • **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Subscriber Agreement • **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** (baldness) treatments, medications, supplies, and devices • **Halfway houses** • **Hearing aids** and the evaluation for the fitting of hearing aids • **Home sleep studies** • **Hospice benefits are limited** as specified in the Subscriber Agreement • **Hospital, physician, mid-wife and other charges** related to prenatal care and delivery of a newborn child 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/orthodontics • **Maternity/ Obstetrical Care** including, but not limited to, any condition which is pregnancy related, prenatal care, delivery or voluntary pregnancy termination, and post natal care unless the Optional Maternity Benefit Rider is included • **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 not a Member or when the transplant procedure is not covered • **Mental Health Services and medications** • **New medications** for which determination of criteria has not yet been established by PIC • **Nutritional supplements** unless for prenatal care as prescribed by the attending Physician or as a 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,** with the exception of approved over-the-counter medications as determined by PIC's Pharmacy and Therapeutics Committee • **Personal or comfort items, services or treatments** • **Photophoresis** 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) as specified in the Subscriber Agreement • **Prescription Drugs** received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available • **Prescription Drugs requiring a Benefit Certification when Certification was not obtained** • **Prescriptions** purchased at a Non-Participating Pharmacy, unless due to an emergency occurring outside of the PIC Service Area • **Prescription** compounded medications • **Prescription Drug** replacements due to loss, theft, or destruction • **Private Duty Nursing** • **Psychological** testing • **Replacement prescriptions** resulting from loss, theft, or destruction • **Residential Treatment Centers** • **Reversals of voluntary sterilization** • **Routine services**, other than emergent or urgent in nature, received **outside of the United States** • **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 is not obtained • **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 • **Special education**, except as covered under the Family, Infant and Toddler (FIT) program • **Special Medical Foods**, except as listed as Covered in the Subscriber Agreement • **Storage or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue • **"Telephone visits"** 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** expenses, except as provided in the Subscriber Agreement • **Vision Care (routine) and Eye Refraction** for determining prescriptions for corrective lenses, except as listed as covered in the Subscriber Agreement • **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

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