PRESBYTERIAN HIGH OPTION – SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA High Option PPO Health Plan benefits **EFFECTIVE July 1, 2018**. The Summary Plan Description supersedes any information outlined in this summary.

NMPSIA High Option PPO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	In-Network Care[1]	**Out-of-Network**[1]
Calendar Year Deductible[1] Individual Family	 $750 $1,500	 $1,500 $3,000
Annual Out-of-Pocket Limit Individual Family	 $3,750 $7,500	 $9,000 $18,000
Office Visits/Exam Charge Office and Home visits/Exams or Consultation (Other services received during the office visit and listed under "Other Services," below, such as therapy, are subject to Deductible, copay, and/or coinsurance as listed in the rest of the summary) **Primary Care office/ Home Visit** **Specialty Care/Office/Home Visit** **Video Visits (Virtual Video Visits)**	*(deductible waived)* **Office Visit Copay** $30 $50 No Charge	 30% 30% Not Covered
Office Surgery (including cast, splints, and dressing)[2]	20%	30%
Allergy Injections (only), Extract Preparation	No Charge (deductible waived)	30%
Therapeutic Injections: Allergy Testing and Treatment	Office Visit Copay	30%
Routine /Preventive Services Routine Adult Physicals and Gynecological Exams, Routine Tests (including Pap Tests, Cholesterol tests, Urinalysis, Human Papillomavirus (HPV) Screening, Colonoscopies and Mammograms (one covered at 100% annually regardless of diagnosis when in-network), Health Education Counseling (including diabetic and smoking cessation counseling), Family Planning (including insertion/removal of birth control devices, surgical sterilization in office, birth control & therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings through age 19	No Charge (deductible waived)	30% (deductible waived)
Acupuncture, Chiropractic (Spinal Manipulation),Message Therapy (if medically necessary),**and, Rolfing** (combined max. benefit of 30 visits/calendar year) **Naprapathy** (Limit $500 per year)	$50 copay (deductible waived) $50 copay (deductible waived)	30% Not Covered
Ambulance Services: Ground and Emergency Air Transport	$30 copay (deductible waived)	
Ambulance Services[2]**:** Inter-facility Transport	$0 (deductible waived)	
Autism Spectrum Disorder[2]**:** Diagnosis and Treatment of all children up to age 19 or up to age 22 if still attending school. Up to 90 visits per member per year (in and out-of-network combined). PCP copay for Applied Behavioral Analysis (ABA) [2]. Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	(deductible waived) PCP $30 copay Specialist $50 copay	30%
Biofeedback (for specific medical conditions only)	$50 copay (deductible waived)	30%
Cardiac and Pulmonary Rehabilitation[2]	$50 copay (deductible waived)	30%
Dental/Facial Accident, Oral Surgery & TMJ/CMJ [2]	Varies by service	30%

[1] All services are subject to deductible unless otherwise indicated in the Summary of Benefits (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made (excluding routine services, hearing aids for children under age 21 and drugs and items covered under the drug plan).

[2]***Prior Authorization may be required*** Primary Care Physicians include, but are not limited to: General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). A list of Practitioners who serve as In-network Primary Care Physicians may be found in the PHP Provider Directory at www.phs.org

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	In-Network Care[1]	**Out-of-Network**[1]
Emergency Room Treatment Physician and Other Professional Provider Changes	$150 copay plus 20% coinsurance per visit	
Hearing Aids and Related Services (**Age 21 & older**: Routine exams/testing not covered.)	**Hearing Aids** No charge up to $500 thereafter you pay 90% coinsurance in any 36-month period	
Hearing Aids and Related Services (**Under age 21**: Exam/testing subject to usual cost-sharing)	**Hearing Aids:** No charge up to $2,200 per hearing impaired ear thereafter you pay 90% coinsurance in any 36-month period	
Home Health Care/Home I.V. Services[2] Limitations	20% Unlimited	30% **120 visits**/calendar
Hospice Services [2] including respite care (limited to 10 days for each6-month per hospice period – 2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period)	No charge (deductible waived)	30%
Infertility: Diagnosis Only- No Treatment	Varies by service	30%
Lab, X-Ray, and Other Basic Diagnostic Tests non-routine (Office/Freestanding Lab or Radiology)	$30 copay or actual allowable amount whichever is less, per day (deductible waived)	30%
Lab, X-Ray, and Other Basic Diagnostic Tests non-routine (Outpatient Department of Hospital)	$60 copay or actual allowable amount whichever is less, per day (deductible waived)	30%
High Tech Imaging: MRI, MRA, CT Scan, PET Scan[2]	$600 Copay or 20% whichever is less, per test, per day.(deductible waived)	30%
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	No charge	30%
Prothrombin Time Test	$10 copay (deductible waived)	30%
Sleep Study	20%	30%
Inpatient Hospital/Facility Services[2] (High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.)		
Medical/Surgical Acute Care, and, **Maternity-Related** Room & Board, Covered Ancillaries, Related Professional charges, **Skilled Nursing Facility**[2] **(max. 60** days/calendar year) **Inpatient Physical Rehabilitation**[2]	$500 facility copay per admission plus 20%	30%
Observation Stay including Related Professional Charges	$100 facility copay plus 20%	30%
Maternity Services		
Physician/Midwife Services (delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	$30 Office Visit Copay/Initial visit	30%
Hospital Admission[2] (Including routine newborn charges)	$500 copay per pregnancy plus 20%	
Extended Stay[2] (non-routine) Charges for covered Newborn	$500 facility copay/admission plus 20%	
Home Birth	20%	

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[2]***Prior Authorization may be required*** Primary Care Physicians include, but are not limited to: General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians/Gynecologists (if applicable). A list of Practitioners who serve as In-network Primary Care Physicians may be found in the PHP Provider Directory at www.phs.org

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	In-Network Care[1]	**Out-of-Network[1]**
Mental Health Services		
Office, Home, Outpatient Facility/Physician	$50 copay (deductible waived)	30%
Inpatient services[2]	$500 copay plus 20%	30%
Partial Hospitalization[2]	$250 copay 20%	30%
Facility- Based Intensive Outpatient Program (IOP)	$125 copay plus 20%	30%
Substance Abuse Rehabilitation (Lifetime max of two courses of treatment for all services combined)		
Office, Home, Outpatient Facility/Physician (**max. 30 days**/calendar year)	$50 copay (deductible waived)	30%
Inpatient [2] (**max. 30 days**/calendar year combined with Partial Hospitalization)	$500 copay per plus 20%	
Partial Hospitalization[2] (**max. 30 days**/calendar year combined with inpatient)	$250 copay plus 20%	
Facility Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	
Residential Treatment Center(RTC)[2] (for adults age 18 & older only) Limit: 60 days/calendar year and 30 days per admit	$250 copay plus 20%	
Outpatient Hospital/Facility/ Ambulatory Surgery Facility[2] (including Related Professional Charges)	$150 copay plus 20%	30%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical, & Speech Therapy Service[2] (Member pays $50 each visit up to a maximum of $500 per calendar year: thereafter plan pays 100% once meet for the remaining calendar year)	$50 copay (deductible waived) Up to $500, thereafter no charge for the remaining calendar year	30%
Smoking/ Tobacco Use Cessation (includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)	No Charge For Prescription Drugs, see your Express Scripts Plan for details	50%
Supplies, Durable Medical Equipment, Prosthetics and Functional Orthotics [2] (Support hose limited to **12 pair** (or **24 hose**) (Mastectomy Bras up to 6 per calendar year.) Prior Authorization needed for services over $1,000.	20%	30%
Insulin Pump Supplies (insertion sets, reservoirs)	No Charge (deductible waived)	30%
Therapy: Chemotherapy and Radiation Therapy	No Charge (deductible waived)	30%
Therapy: Dialysis * See Summery plan Description for Out-of-Network	20%	30%
Transplant Services [2] Maximums apply to donor charges and travel and lodging. Must be received at a facility that contracts with Presbyterian Health Plan.	Applicable copay based on place of service	Not Covered
Urgent Care Center (includes all services and supplies such as x-ray/labs/physician fees)	$50 copay (deductible waived)	30%
Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products Administered by Express Scripts –Call Express Scripts Customer Service Center at 1-800-498-4904		

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Presbyterian Health Services (Presbyterian) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Presbyterian does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian:

- provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at 505-923-5420, 855-592-7737, TTY 711.

If you believe that Presbyterian has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Presbyterian Privacy Officer and Civil Rights Coordinator, P.O. Box 27489, Albuquerque, NM, 87125, or call 866-977-3021. You can file a grievance in person, by mail, email, or the above phone number. If you need help filing a grievance, call 866-977-3021 and a customer representative will assist you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint

Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*** **,** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***

MULTI-LANGUAGE INTERPRETER SERVICES

English
Attention: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-797-5343 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-797-5343 (TTY: 711).

Navajo
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-797-5343 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-797-5343 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-797-5343 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-797-5343 (TTY: 711)

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-797-5343 (رقم هاتف الصم والبكم) (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-797-5343 (TTY: 711) 번으로 전화해 주십시오.

Tagalog

MULTI-LANGUAGE INTERPRETER SERVICES

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-797-5343 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-797-5343 (TTY:711）まで、お電話にてご連絡ください。

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-797-5343 (ATS: 711).

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-797-5343 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-797-5343 (телетайп: 711).

Hindi

ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।
1-800-797-5343 (TTY: 711) पर कॉल कर।

Farsi/Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-797-5343 (TTY: 711) تماس بگیرید.

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-797-5343 (TTY: 711).