Schedule of Benefits

Concordia Preferred [sm]

Group Name: NM RETIREE HEALTH CARE AUTHORITY
Group Number(s): 812020120 Effective Date: January 1, 2019

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Insured Pays In-Network" and "Insured Pays Out-of-Network" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period". Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application In-Network" and "Deductible Application Out-of-Network" columns will indicate "no". If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application In-Network" and "Deductible Application Out-of-Network" columns. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Participating Dentists accept the Maximum Allowable Charge as payment in full.

Service Category	Waiting Period	Insured Pays In-Network	Insured Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Diagnostic Services					
Oral Evaluation (Exams)	***None***	***0%***	***0%***	***No***	***No***
Radiographs (X-Rays)					
Bitewings	***None***	***0%***	***0%***	***No***	***No***
Full mouth	***None***	***0%***	***0%***	***No***	***No***
Preventive Services					
Prophylaxis (Cleanings)	***None***	***0%***	***0%***	***No***	***No***
Topical Fluoride	***None***	***0%***	***0%***	***No***	***No***
Sealants	***None***	***0%***	***0%***	***No***	***No***
Space Maintainers	***None***	***20%***	***45%***	***Yes***	***Yes***
Restorative Services					
Amalgam Restorations	***None***	***20%***	***45%***	***Yes***	***Yes***
Resin Based Composite --Anterior (White Fillings)	***None***	***20%***	***45%***	***Yes***	***Yes***

Service Category	Waiting Period	Insured Pays In-Network	Insured Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Resin Based Composite-Posterior (White Filling)	***None***	***20%***	***45%***	***Yes***	***Yes***
Single Crowns	***None***	***50%***	***65%***	***Yes***	***Yes***
Stainless Steel Crowns	***None***	***20%***	***45%***	***Yes***	***Yes***
Inlays	***None***	***50%***	***65%***	***Yes***	***Yes***
Onlays	***None***	***50%***	***65%***	***Yes***	***Yes***
Inlay Repairs	***None***	***20%***	***45%***	***Yes***	***Yes***
Onlay Repairs	***None***	***20%***	***45%***	***Yes***	***Yes***
Crown Repair	***None***	***20%***	***45%***	***Yes***	***Yes***
Endodontic Services					
Endodontic Therapy (Root Canals, etc.)	***None***	***20%***	***45%***	***Yes***	***Yes***
Root Canal Retreatment	***None***	***20%***	***45%***	***Yes***	***Yes***
Apicoectomy/Periradicular (Root Surgery)	***None***	***20%***	***45%***	***Yes***	***Yes***
Periodontal Services					
Surgical Periodontics	***None***	***20%***	***45%***	***Yes***	***Yes***
Non-Surgical Periodontics	***None***	***20%***	***45%***	***Yes***	***Yes***
Periodontal Maintenance	***None***	***20%***	***45%***	***Yes***	***Yes***
Prosthodontic Services					
Removable Complete and Partial Dentures	***None***	***50%***	***65%***	***Yes***	***Yes***
Adjustments and Repairs of Complete and Partial Dentures	***None***	***20%***	***45%***	***Yes***	***Yes***
Removal of Teeth					
Simple Extractions	***None***	***20%***	***45%***	***Yes***	***Yes***
Surgical Removal	***None***	***20%***	***45%***	***Yes***	***Yes***

Service Category	Waiting Period	Insured Pays In-Network	Insured Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Adjunctive General Services					
Consultations	***None***	***0%***	***0%***	***No***	***No***
General Anesthesia, Nitrous Oxide and/or IV Sedation	***None***	***20%***	***45%***	***Yes***	***Yes***
Palliative Treatment (Emergency)	***None***	***0%***	***0%***	***No***	***No***
Orthodontic Services					
Cosmetic Orthodontic Services	***None***	***50%***	***50%***	***No***	***No***

Deductibles & Maximums In-Network

- *$50 per calendar year Deductible per Member not to exceed $150 per family*
- *$1,500 per calendar year Maximum per Member*
- *$1,000 lifetime Maximum per Member for Orthodontics*

Deductibles & Maximums Out-of-Network

- *$50 per calendar year Deductible per Member not to exceed $150 per family*
- *$1,000 per calendar year Maximum per Member*
- *$500 lifetime Maximum per Member for Orthodontics*