

# PRESBYTERIAN HIGH OPTION – SUMMARY OF BENEFITS

<b>This is only a summary</b> that lists the member cost-sharing amounts and provides a brief description of NMPSIA High Option PPO Health Plan benefits <b>EFFECTIVE July 1, 2018</b> . The Summary Plan Description supersedes any information outlined in this summary.		
	<b>Member's Share of Covered Charges</b>	
	<b>In-Network Care<sup>(1)</sup></b>	<b>Out-of-Network<sup>(1)</sup></b>
<b>NMPSIA High Option PPO Benefits</b> There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.		
<b>Calendar Year Deductible<sup>(1)</sup></b>		
Individual	\$750	\$1,500
Family	\$1,500	\$3,000
<b>Annual Out-of-Pocket Limit</b>		
Individual	\$3,750	\$9,000
Family	\$7,500	\$18,000
<b>Office Visits/Exam Charge</b> 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)	<i>(deductible waived)</i>	
	<b>Office Visit Copay</b>	
<b>Primary Care office/ Home Visit</b>	\$30	30%
<b>Specialty Care/Office/Home Visit</b>	\$50	30%
<b>Video Visits (Virtual Video Visits)</b>	No Charge	Not Covered
<b>Office Surgery (including cast, splints, and dressing)<sup>(2)</sup></b>	20%	30%
<b>Allergy Injections (only), Extract Preparation</b>	No Charge (deductible waived)	30%
<b>Therapeutic Injections: Allergy Testing and Treatment</b>	Office Visit Copay	30%
<b>Routine /Preventive Services</b>		
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)
<b>Acupuncture, Chiropractic (Spinal Manipulation), Message Therapy (if medically necessary), Naprapathy and, Roling</b> (combined max. benefit of 30 visits/calendar year)	\$50 copay (deductible waived)	30%
<b>Ambulance Services:</b> Ground and Emergency Air Transport	\$30 copay (deductible waived)	
<b>Ambulance Services<sup>(2)</sup>:</b> Inter-facility Transport	\$0 (deductible waived)	
<b>Autism Spectrum Disorder<sup>(2)</sup>:</b>		30%
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) <sup>(2)</sup> . Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	(deductible waived) PCP \$30 copay Specialist \$50 copay	
<b>Biofeedback</b> (for specific medical conditions only)	\$50 copay (deductible waived)	30%
<b>Cardiac and Pulmonary Rehabilitation<sup>(2)</sup></b>	\$50 copay (deductible waived)	30%
<b>Dental/Facial Accident, Oral Surgery &amp; TMJ/CMJ <sup>(2)</sup></b>	Varies by service	30%
<b>Emergency Room Treatment</b>		
Physician and Other Professional Provider Changes	\$150 copay plus 20% coinsurance per visit	\$150 copay plus 20% coinsurance per visit

<sup>(1)</sup> **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).

<sup>(2)</sup> **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](http://www.phs.org)

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	<b>In-Network Care<sup>(1)</sup></b>	<b>Out-of-Network<sup>(1)</sup></b>
<b>Hearing Aids and Related Services</b> (Age 21 & older: Routine exams/testing not covered.)	<b>Hearing Aids</b> No charge up to \$500 thereafter you pay 90% coinsurance in any 36-month period	
<b>Hearing Aids and Related Services</b> (Under age 21: Exam/testing subject to usual cost-sharing)	<b>Hearing Aids:</b> No charge up to \$2,200 per hearing impaired ear thereafter you pay 90% coinsurance in any 36-month period	
<b>Home Health Care/Home I.V. Services<sup>(2)</sup></b> Limitations	20% Unlimited	30% <b>120 visits</b> /calendar
<b>Hospice Services<sup>(2)</sup></b> including respite care (limited to 10 days for each 6-month per hospice period – 2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period)	No charge (deductible waived)	30%
<b>Infertility: Diagnosis Only- No Treatment</b>	Varies by service	30%
<b>Lab, X-Ray, and Other Basic Diagnostic Tests</b> non-routine (Office/Freestanding Lab or Radiology)	\$30 copay or actual allowable amount whichever is less, per day (deductible waived)	30%
<b>Lab, X-Ray, and Other Basic Diagnostic Tests</b> non-routine (Outpatient Department of Hospital)	\$60 copay or actual allowable amount whichever is less, per day (deductible waived)	30%
<b>High Tech Imaging: MRI, MRA, CT Scan, PET Scan<sup>(2)</sup></b>	\$600 Copay or 20% whichever is less, per test, per day.(deductible waived)	30%
<b>Professional Interpretation &amp; Reading</b> (Lab, X-Ray, & High Tech)	No charge	30%
<b>Prothrombin Time Test</b>	\$10 copay (deductible waived)	30%
<b>Sleep Study</b>	20%	30%
<b>Inpatient Hospital/Facility Services<sup>(2)</sup></b> (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.)		
<b>Medical/Surgical Acute Care, and, Maternity-Related</b> Room & Board, Covered Ancillaries, Related Professional charges, <b>Skilled Nursing Facility<sup>(2)</sup></b> (max. 60 days/calendar year) <b>Inpatient Physical Rehabilitation<sup>(2)</sup></b>	\$500 facility copay per admission plus 20%	30%
<b>Observation Stay</b> including Related Professional Charges	\$100 facility copay plus 20%	30%
<b>Maternity Services</b>		
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 <sup>(2)</sup> (Including routine newborn charges)	\$500 copay per pregnancy plus 20%	
Extended Stay <sup>(2)</sup> (non-routine) Charges for covered Newborn	\$500 facility copay/admission plus 20%	
Home Birth	20%	
<b>Mental Health Services</b>		
Office, Home, Outpatient Facility/Physician	\$30 copay (deductible waived)	30%
Inpatient services <sup>(2)</sup>	\$500 copay plus 20%	30%

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Partial Hospitalization <sup>(2)</sup>	\$250 copay plus 20%	30%
Facility- Based Intensive Outpatient Program (IOP)	\$125 copay plus 20%	30%
<b>Substance Abuse Rehabilitation</b> (Lifetime max of two courses of treatment for all services combined)		
Office, Home, Outpatient Facility/Physician (max. 30 days/calendar year)	\$30 copay (deductible waived)	30%
Inpatient <sup>(2)</sup> (max. 30 days/calendar year combined with Partial Hospitalization)	\$500 copay per plus 20%	
Partial Hospitalization <sup>(2)</sup> (max. 30 days/calendar year combined with inpatient)	\$250 copay plus 20%	
Facility Based Intensive Outpatient Programs (IOP)	\$125 copay plus 20%	
<b>Residential Treatment Center(RTC)</b> <sup>(2)</sup> (for adults age 18 & older only) Limit: 60 days/calendar year and 30 days per admit	\$250 copay plus 20%	
<b>Outpatient Hospital/Facility/ Ambulatory Surgery Facility</b> <sup>(2)</sup> (including Related Professional Charges)	\$150 copay plus 20%	30%
<b>Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical, &amp; Speech Therapy Service</b> <sup>(2)</sup> (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%
<b>Smoking/ Tobacco Use Cessation</b> (includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)	No Charge	50%
	For Prescription Drugs, see your Express Scripts Plan for details	
<b>Supplies, Durable Medical Equipment, Prosthetics and Functional Orthotics</b> <sup>(2)</sup> (Support hose limited to <b>12 pair</b> (or <b>24 hose</b> ) (Mastectomy Bras up to 6 per calendar year.) Prior Authorization needed for services over \$1,000.	20%	30%
<b>Insulin Pump Supplies</b> (insertion sets, reservoirs)	No Charge (deductible waived)	30%
<b>Therapy: Chemotherapy and Radiation Therapy</b>	No Charge (deductible waived)	30%
<b>Therapy: Dialysis</b> * See Summary plan Description for Out-of-Network	20%	30%
<b>Transplant Services</b> <sup>(2)</sup> 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
<b>Urgent Care Center</b> (includes all services and supplies such as x-ray/labs/physician fees)	\$50 copay (deductible waived)	30%
<b>Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products</b> Administered by Express Scripts –Call Express Scripts Customer Service Center at 1-800-498-4904		

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- provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

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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>