Summary of Benefits

The following are the highlights of the PPO plan administered by Presbyterian Health Plan, Inc. for County of Bernalillo employees statewide. These benefits are effective 7/1/18 through 6/30/2019. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4, and 5 of the Summary Plan Description.

BENEFITS	**PPO PLAN**		
		In-network Care	**Out-of-network**
Benefit Highlights	Member Copayment/Coinsurance	Varies depending on service; see below	
	Plan Year Deductible Individual Family	$750 $1,500	$1,500 $3,000
	Plan Year Out-of-pocket Maximum **(When the deductible, medical Copayments and Coinsurance add up to these amounts, the plan will pay 100% of the allowed amount for the remainder of the Plan Year)** Individual Family Limit	$5,000 $10,000	$10,000 $20,000
	Lifetime maximum	Unlimited **(Certain services are subject to Plan Year and/or Lifetime Maximums or are limited per condition.)**	
Physician Services	Office visits ***(other services received during the office visit, such as lab work, or surgery, are subject to Deductible and Coinsurance)*** Primary care Specialty care	$30 Copayment [2] $60 Copayment [2]	50% Coinsurance 50% Coinsurance
	Routine Well Care		
	Routine Physicals	No Copayment [2]	50% Coinsurance
	Well Child Care including vision and hearing screening (through age 17)	No Copayment [2]	50% Coinsurance
	Immunizations, and travel immunizations	No Copayment [2]	50% Coinsurance
	Adult wellness	No Copayment [2]	50% Coinsurance
	Related Testing (Deductible waived for tests, including routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, Human Papillomavirus (HPV) screening, etc., and immunizations.)	No Copayment [2]	50% Coinsurance
	Family Planning Birth control injections, insertion/removal of birth control devices (All contraceptives In-Network)	No Charge [2]	50% Coinsurance
	Surgery in office	Included in office visit Copayment	50% Coinsurance
	Therapeutic Injections	Office visit Copayment	50% Coinsurance
	Allergy testing and treatment	20% Coinsurance	50% Coinsurance
	Allergy injections only	Included in Office visit Copayment (waived if nursing visit only)	50% Coinsurance
	Allergy extract preparation	20% Coinsurance	50% Coinsurance

BENEFITS	PPO PLAN		
		In-network Care	**Out-of-network**
Outpatient Diagnostic Testing	MRI or PET Scans [1]	$200 Copayment per test [2]	50% Coinsurance
	CT Scans [1]	$125 Copayment per test [2]	50% Coinsurance
	Other laboratory and x-ray	No Copayment Outpatient [2]	50% Coinsurance
	Home/Sleep study	$50 Copayment per study [2]	50% Coinsurance
Hospital Services	Hospitalization [1] (includes room and board, Inpatient physician care – physician visits, surgeon, anesthesiologist, laboratory and x-ray)	20% Coinsurance	50% Coinsurance
	Inpatient rehabilitation services	20% Coinsurance	50% Coinsurance
	Observation stay	No Copayment [2]	50% Coinsurance
Surgical Services	Inpatient Surgery [1]	Covered as part of hospitalization	50% Coinsurance
	Outpatient Surgery [1]	20% Coinsurance	50% Coinsurance
	Office Surgery	Included in office visit Copayment	50% Coinsurance
Maternity Services	Physician/midwife services (delivery, prenatal/postnatal care)	$30 Copayment [2]	50% Coinsurance
	Hospital Admission [1] (Including routine nursery care for newborns)	20% Coinsurance	50% Coinsurance
	Extended stay (non-routine) for covered newborn	20% Coinsurance	50% Coinsurance
	Home Birth	**Not Covered**	**Not Covered**
Urgent and Emergency Services	Urgent Care center	$75 Copayment [2]	$75 Copayment
	Emergency Room visit	$250 Copayment/visit [2]	
	Ambulance – emergency	$50 Copayment per trip [2]	
	Air transport	$100 Copayment per trip [2]	
	Inter-facility transport	No Copayment [2]	
Mental Health	Outpatient services [5]	$30 Copayment per visit [2]	50% Coinsurance
	Inpatient services [3]	20% Coinsurance	50% Coinsurance
	Partial Hospitalization [3]	20% Coinsurance	50% Coinsurance
	Facility based intensive Outpatient program	20% Coinsurance	50% Coinsurance
Substance Abuse	Outpatient services	$30 Copayment per visit [2]	50% Coinsurance
	Inpatient services [1]	20% Coinsurance	50% Coinsurance
	Partial hospitalization [1]	20% Coinsurance	50% Coinsurance
	Facility based intensive Outpatient program	20% Coinsurance	50% Coinsurance
	Residential Treatment Centers [1]	**Not Covered**	**Not Covered**

BENEFITS	PPO PLAN		
		In-network Care	Out-of-network
Other Services	Acupuncture (Not combined, annual limit of 18 visits) Chiropractic (Not combined, annual limit of 18 visits)	$50 Copayment per visit [2] $60 Copayment per visit [2]	50% Coinsurance 50% Coinsurance
	Biofeedback (for specified medical conditions only)	$30 Copayment per visit [2]	50% Coinsurance
	Cardiac or pulmonary rehabilitation	$75 Copayment per session [2] – Up to 24 sessions per contract year. Will not be combined with other rehabilitation therapies	50% Coinsurance
	Chemotherapy and/or radiation therapy	Copayment [2] or Coinsurance based on service	50% Coinsurance
	Dental services (for specified medical conditions only)	Copayment [2] or Coinsurance based on service	50% Coinsurance
	Dialysis	20% Coinsurance	50% Coinsurance
	Durable Medical Equipment, Orthotics, Prosthetics and appliances [1]	50% Coinsurance	50% Coinsurance
	Hearing Aids School-aged children (Every 36 months per "hearing impaired ear")	20% Coinsurance	50% Coinsurance
	Home health nursing care	20% Coinsurance	50% Coinsurance
	Hospice [1]	Inpatient - 20% Coinsurance In home - No Copayment [2]	50% Coinsurance
	Infertility related services ***(only limited services covered)***	50% Coinsurance	**Not Covered**
	Physical, occupational and speech therapy [1] ***Coverage is limited to 24 visits per service***	$75 Copayment [2]	50% Coinsurance
	Skilled Nursing facility [1] *(max 30 days per Plan Year)*	20% Coinsurance	50% Coinsurance
	Smoking cessation (including acupuncture, related test, and any counseling programs not eligible under preventive)	Applicable Copayment [2] or Coinsurance based on place of service	**Not Covered**

BENEFITS	PPO PLAN		
		In-network Care	Out-of-network
Transplants	Coverage for human organ transplants [1] (refer to booklet for details on transplant coverage and call for case management services)	20% Coinsurance	Not Covered
Autism Spectrum Disorder (Habilitative)	Treatment through or provided by:		
	PCP	$20 Copayment per visit [1]	50% Coinsurance
	Specialist	$30 Copayment per visit [1]	50% Coinsurance
	Outpatient Physical Therapy	$30 Copayment per visit [1]	50% Coinsurance
	Outpatient Occupational Therapy	$30 Copayment per visit [1]	50% Coinsurance
	Outpatient Speech Therapy	$30 Copayment per visit [1]	50% Coinsurance
	Applied Behavioral Analysis (ABA) [1]	$20 Copayment per visit [1]	50% Coinsurance
	Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school.		
	Up to 90 visits per member per Plan Year		
Prescription Drugs	Generic Drugs Preferred brand drugs Non-preferred drugs Specialty drugs	Administered by Express Scripts – Contact at 1-855-315-3413	

[1] **Prior authorization may be required**

[2] **Not subject to deductible**

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/directory.