PRESBYTERIAN
Health Plan, Inc.

HEALTH CARE AUTHORITY

The following are the highlights of the Point-of-Service plan administered by Presbyterian Health Plan, Inc. for State of New Mexico employees statewide. These benefits are effective 7/1/2026 - 6/30/2027. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4 and 5 of the Summary Plan Description.

SUMMARY OF BENEFITS HMO PLANS	HMO CLEAR COST PLATINUM		HMO BASIC GOLD	
	Tier I	Tier II	Tier I	Tier II
Deductible • The deductible does not apply to Preventive Care Services or Prescription Drugs. • Copays do not apply towards deductible. • Except for Preventive Care and those services where a copay applies, the deductible must be met before benefit payment is made by the plan (coinsurance applies). • After each family member meets his or her individual plan deductible, the plan will pay a percentage of his or her claims and the member will pay applicable coinsurance until the out-ofpocket maximum is met. • After the family plan deductible has been met, the plan will pay a percentage of each individual's claims and the member(s) will pay applicable coinsurance until the out-of-pocket maximum is met. • Deductible amounts cross-accumulate between Tier I, Tier II.	$0 Individual $0 Two-party $0 Family	$300 Individual $600 Two-party $900 Family	$500 Individual $1,000 Two-party $1,500 Family	$700 Individual $1,400 Two-party $2,100 Family
Out-of-Pocket Maximum • The medical plan copays, deductible and coinsurance apply to the annual out-of-pocket maximum. • Prescription drug copays or coinsurance paid through CVS do apply to the medical plan out-of-pocket maximum. The prescription drug plan and medical plan have a combined out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of that individual's covered expenses. • After the family out-of-pocket maximum has been met, the plan will pay 100% of each family member's covered expenses. • Out-of-pocket amounts cross-accumulate between Tier I, Tier II.	$3,500 Individual $7,000 Two-party $10,500 Family	$4,250 Individual $8,500 Two-party $12,750 Family	$4,000 Individual $8,000 Two-party $12,000 Family	$5,000 Individual $10,000 Two-party $15,000 Family
Member Coinsurance	0%	20%	30%	30%
Primary Care (Visit to treat an injury or illness excluding Preventive and X-rays)	$20	$30	$30	$40
Preventive Care/Screening/Immunization [1] • Routine Physical • Annual women's exam • Annual men's exam including PSA • Related laboratory tests including X-rays (includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well childcare including vision and hearing screenings (through age 21) • Immunizations • Health education and counseling (including smoking/ tobacco cessation education) • Family planning	$0	$0	$0	$0

SUMMARY OF BENEFITS HMO PLANS	HMO CLEAR COST PLATINUM		HMO BASIC GOLD	
	Tier I	Tier II	Tier I	Tier II
Specialist Visit	$40	$60	$60	$80
Urgent Care Facility	$50	$70	$80	$100
Emergency Room Services [4]	$250 (waived if admitted)	$250 (waived if admitted)	$350 (waived if admitted)	$350 (waived if admitted)
Ambulance (Emergency Ground or Air Transport)	Ground $100 Air $200	Ground $100 Air $200	30% after deductible, coinsurance (Tier I deductible applies)	30% after deductible, coinsurance (Tier I deductible applies)
Virtual Care Services All Medical and Behavioral Virtual Care Services (Telephonic or Video) • Primary Care • Specialty Care • Urgent Care	$0	$0	$0	$0
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-447-5521			
Laboratory Outpatient and Professional Services	$20	$30	$30	$40
X-ray and Diagnostic Imaging	$75	$100	$100	$120
Imaging (CT/PET Scans, MRIs) [2]	$75	$100	30% coinsurance after deductible; up to $250	30% coinsurance after deductible; up to $250
Maternity Services	$750 per admission	$1,250 per admission	30% coinsurance after deductible	30% coinsurance after deductible
Routine nursery care for newborn • If mother is covered under the plan, baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 30 days from date of birth.	$0	$0	$0	$0
Transplant [5] Coverage for human organ transplants • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage. Maximums apply to covered travel and lodging services.	Copay based on place of service	Copay based on place of service	Copay based on place of service	Copay based on place of service
Speech, Occupational and Physical Therapy [3]	$20	$30	$30	$40
Skilled Nursing Facility [3]	$750 per admission	$1,250 per admission	30% after deductible	30% after deductible
Outpatient Surgery Physician/Surgical Services [2] **and Facility Fees** (e.g., Ambulatory Surgery Center)	$75	$100	30% coinsurance after deductible	30% coinsurance after deductible

SUMMARY OF BENEFITS HMO PLANS	HMO CLEAR COST PLATINUM		HMO BASIC GOLD	
	Tier I	Tier II	Tier I	Tier II
Outpatient Mental/Behavioral Health and Substance Use Disorder Services	$0	$0	$0	$0
Outpatient Facility Fee – Mental Health	$0	$0	$0	$0
Inpatient Hospital Services [2] (excluding Mental Health/Substance Use Disorder)	$750 per admission	$1,250 per admission	30% coinsurance after deductible	30% coinsurance after deductible
Inpatient Mental Health/Substance Use Disorder (SUD)	$0	$0	$0	$0
Allergy Testing and Treatment	$40	$60	$60	$80
Allergy Injections only	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Allergy Extraction Preparation	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Acupuncture [3] (limited to 25 visits combined/plan year)	$40	$60	$60	$80
Chiropractic [3] (limited to 25 visits combined/plan year)	$20	$30	$30	$40
Naprapathic Services, Massage Therapy [3] (limited to 25 visits combined / plan year). No copay applies for behavioral health for HMOs and PPO in-network	$40	$60	$60	$80
Autism Spectrum Disorders [2] • Diagnosis and treatment of autism spectrum disorder • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Cardiac Rehab [2] **and Pulmonary Rehab** [2]	Specialist office visit copays apply	Specialist copays apply for office visits, other 20%	Specialist copays apply for office visits, other 30% after deductible	Specialist copays apply for office visits, other 30% after deductible
Chemotherapy and/or Radiation Therapy	Specialist copay applies for office visits, other outpatient place of service 20%	Specialist copay applies for office visits, other outpatient place of service 20%	Specialist copay applies for office visits, other outpatient place of service 30% after deductible	Specialist copay applies for office visits, other outpatient place of service 30% after deductible
Dialysis	PCP copay applies for office visits, other outpatient place of service 20%	PCP copay applies for office visits, other outpatient place of service 20%	PCP copay applies for office visits, other outpatient place of service 30% after deductible	PCP copay applies for office visits, other outpatient place of service 30% after deductible
Diabetes Coverage (office visit and diabetes education)	PCP and specialist copays apply	PCP and specialist copays apply	PCP and specialist copays apply	PCP and specialist copays apply

SUMMARY OF BENEFITS HMO PLANS	HMO CLEAR COST PLATINUM		HMO BASIC GOLD	
	Tier I	Tier II	Tier I	Tier II
Diabetic supplies, equipment, appliances, and services [2] • Prescribed by the attending physician • Purchased through a Durable Medical Equipment (DME) provider	20%	20%	30% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment (DME), orthopedic appliances, prosthetics, and functional orthotics	20%	20%	30% coinsurance after deductible	30% coinsurance after deductible
Hearing Aids (to include repair, replacement and associated testing)	No copay, up to $2,500 per ear every 36 months	No copay, up to $2,500 per ear every 36 months	No copay, up to $2,500 per ear every 36 months	No copay, up to $2,500 per ear every 36 months
Hospice [2] • Bereavement Counseling (Limited to 3 sessions during the hospice benefit period) • Respite Care (Lifetime Maximum of 2 sessions of up to 10 days for each Hospice benefit period)	Plan pays 100%	Plan pays 100%	Plan pays 100% after deductible	Plan pays 100% after deductible
Home Health Care [2] **/ Home Intravenous Service** [2] Prescribed home physician services, nursing care and rehabilitative therapy	$40	$60	$60	$80

[1] The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires health plans to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to the member when the services are provided by an In-Network Participating Provider. Although these services are covered at no charge, the provider may charge a copayment for other services provided during the office visit. Additionally, some covered Family Planning services continue to require member cost-sharing. If you have questions regarding the Preventive Care Services that are covered under this plan, including Family Planning Services, or your cost for these services, please refer to your Evidence of Coverage/Summary Plan Description, or contact Presbyterian Health Plan at the phone number listed on your ID card. These services must be Medically Necessary as defined by the Summary Plan Description.

[2] Pre-Admission Review and/or Prior Authorization is required; $250 penalty, reduction or denial may apply to facility and provider services if the required Pre-Admission Review and/or Prior Authorization is not obtained.

[3] This benefit includes an annual visit limitation. See your Summary Plan Description for more information.

[4] The Emergency Services coinsurance is waived if an inpatient hospital admission results; then the hospital admission deductible and coinsurance applies.

[5] Transplants are covered In-Network only by Tier I or Tier II providers. Case Management Services for transplant patients must be obtained from Presbyterian Health Plan at the phone number listed on your ID card.

[6] Patients are responsible for copay or deductible and coinsurance related to place of service, ancillary services, and additional procedures performed at the same time. Prior Authorization rules still apply.

SUMMARY OF BENEFITS PPO BASIC GOLD	PPO BASIC GOLD		
	Tier I	Tier II	Out-of-Network
Deductible • The deductible does not apply to Preventive Care Services or Prescription Drugs. • Copays do not apply towards deductible. • Except for Preventive Care and those services where a copay applies, the deductible must be met before benefit payment is made by the plan (coinsurance applies). • After each family member meets his or her individual plan deductible, the plan will pay a percentage of his or her claims and the member will pay applicable coinsurance until the out-ofpocket maximum is met. • After the family plan deductible has been met, the plan will pay a percentage of each individual's claims and the member(s) will pay applicable coinsurance until the out-of-pocket maximum is met. • Deductible amounts cross-accumulate between Tier I, Tier II.	$500 Individual $1,000 Two-party $1,500 Family	$700 Individual $1,400 Two-party $2,100 Family	$3,000 Individual $6,000 Two-party $9,000 Family
Out-of-Pocket Maximum • The medical plan copays, deductible and coinsurance apply to the annual out-of-pocket maximum. • Prescription drug copays or coinsurance paid through CVS do apply to the medical plan out-of-pocket maximum. The prescription drug plan and medical plan have a combined out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of that individual's covered expenses. • After the family out-of-pocket maximum has been met, the plan will pay 100% of each family member's covered expenses. • Out-of-pocket amounts cross-accumulate between Tier I, Tier II.	$4,000 Individual $8,000 Two-party $12,000 Family	$6,000 Individual $12,000 Two-party $18,000 Family	$9,000 Individual $18,000 Two-party $27,000 Family
Member Coinsurance	30%	35%	50%
Primary Care (Visit to treat an injury or illness excluding Preventive and X-rays)	$30	$40	50% coinsurance after deductible
Preventive Care/Screening/Immunization [1] • Routine Physical • Annual women's exam • Annual men's exam including PSA • Related laboratory tests including x-rays (includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well childcare including vision and hearing screenings (through age 21) • Immunizations • Health education and counseling (including smoking/tobacco cessation education) • Family planning	$0	$0	50% coinsurance after deductible
Specialist Visit	$60	$80	50% coinsurance after deductible
Urgent Care Facility	$80	$100	50% coinsurance after deductible
Emergency Room Services [4]	$350 (waived if admitted)	$350 (waived if admitted)	$350 (waived if admitted)

SUMMARY OF BENEFITS PPO BASIC GOLD	PPO BASIC GOLD		
	Tier I	**Tier II**	**Out-of-Network**
Ambulance (Emergency Ground or Air Transport)	30% after deductible, coinsurance (Tier I deductible applies)	30% after deductible, coinsurance (Tier I deductible applies)	30% after deductible, coinsurance (Tier I deductible applies)
Virtual Care Services All Medical and Behavioral Virtual Care Services (Telephonic or Video) • Primary Care • Specialty Care • Urgent Care	$0	$0	50% coinsurance after deductible
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-447-5521		
Laboratory Outpatient and Professional Services	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible
X-ray and Diagnostic Imaging	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible
Imaging (CT/PET Scans, MRIs) [2]	30% coinsurance after deductible; up to $300	35% coinsurance after deductible; up to $300	50% coinsurance after deductible
Maternity Services	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible
Routine nursery care for newborn • If mother is covered under the plan, baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 30 days from date of birth.	$0	$0	50% after deductible
Transplant [5] Coverage for human organ transplants • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage. Maximums apply to covered travel and lodging services.	Subject to place of service	Subject to place of service	Not covered
Speech, Occupational and Physical Therapy [3]	$30	$40	50% coinsurance after deductible
Skilled Nursing Facility [3]	30% after deductible	35% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery Physician/Surgical Services [2] **and Facility Fees** (e.g., Ambulatory Surgery Center)	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible

SUMMARY OF BENEFITS PPO BASIC GOLD	PPO BASIC GOLD		
	Tier I	Tier II	Out-of-Network
Outpatient Mental/Behavioral Health and Substance Use Disorder Services	$0	$0	50% coinsurance after deductible
Outpatient Facility Fee – Mental Health	$0	$0	50% coinsurance after deductible
Inpatient Hospital Services [2] (excluding Mental Health/Substance Use Disorder)	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible
Inpatient Mental Health/ Substance Use Disorder (SUD)	$0	$0	50% coinsurance after deductible
Allergy Testing and Treatment	$60	$80	50% coinsurance after deductible
Allergy Injections only	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
Allergy Extraction Preparation	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
Acupuncture [3] (limited to 25 visits combined/plan year)	$60	$80	50% after deductible
Chiropractic [3] (limited to 25 visits combined/plan year)	$30	$40	50% after deductible
Naprapathic Services, Massage Therapy [3] (limited to 25 visits combined / plan year). No copay applies for behavioral health for HMOs and PPO in-network	$60	$80	50% after deductible
Autism Spectrum Disorders [2] • Diagnosis and treatment of autism spectrum disorder • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder	Plan pays 100%	Plan pays 100%	50% coinsurance after deductible
Cardiac Rehab [2] **and Pulmonary Rehab** [2]	Specialist Copays apply for office visits, other 30% after deductible	Specialist Copays apply for office visits, other 35% after deductible	50% coinsurance after deductible
Chemotherapy and/or Radiation Therapy	Specialist copay applies for office visits, other outpatient place of service 30% after deductible	Specialist copay applies for office visits, other outpatient place of service 35% after deductible	50% coinsurance after deductible
Dialysis	PCP copay applies for office visits, other outpatient place of service 30% after deductible	PCP copay applies for office visits, other outpatient place of service 35% after deductible	50% coinsurance after deductible

SUMMARY OF BENEFITS PPO BASIC GOLD	PPO BASIC GOLD		
	Tier I	**Tier II**	**Out-of-Network**
Diabetes Coverage (office visit and diabetes education)	PCP and specialist copays apply	PCP and specialist copays apply	50% coinsurance after deductible
Diabetic supplies, equipment, appliances, and services [2] • Prescribed by the attending physician • Purchased through a Durable Medical Equipment (DME) provider	30% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME), orthopedic appliances, prosthetics, and functional orthotics	30% coinsurance after deductible	35% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids (to include repair, replacement and associated testing)	No copay, up to $2,500 per ear every 36 months	No copay, up to $2,500 per ear every 36 months	50% after deductible, up to $2,500 per ear every 36 months
Hospice [2] • Bereavement Counseling (Limited to 3 sessions during the hospice benefit period) • Respite Care (Lifetime Maximum of 2 sessions of up to 10 days for each Hospice benefit period)	Plan pays 100% after deductible	Plan pays 100% after deductible	50% after deductible
Home Health Care [2] **/ Home Intravenous Service** [2] Prescribed home physician services, nursing care and rehabilitative therapy	$60	$80	50% coinsurance after deductible

[1] The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires health plans to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to the member when the services are provided by an In-Network Participating Provider. Although these services are covered at no charge, the provider may charge a copayment for other services provided during the office visit. Additionally, some covered Family Planning services continue to require member cost-sharing. If you have questions regarding the Preventive Care Services that are covered under this plan, including Family Planning Services, or your cost for these services, please refer to your Evidence of Coverage/Summary Plan Description, or contact Presbyterian Health Plan at the phone number listed on your ID card. These services must be Medically Necessary as defined by the Summary Plan Description.

[2] Pre-Admission Review and/or Prior Authorization is required; $250 penalty, reduction or denial may apply to facility and provider services if the required Pre-Admission Review and/or Prior Authorization is not obtained.

[3] This benefit includes an annual visit limitation. See your Summary Plan Description for more information.

[4] The Emergency Services coinsurance is waived if an inpatient hospital admission results; then the hospital admission deductible and coinsurance applies.

[5] Transplants are covered In-Network only by Tier I or Tier II providers. Case Management Services for transplant patients must be obtained from Presbyterian Health Plan at the phone number listed on your ID card.

[6] Patients are responsible for copay or deductible and coinsurance related to place of service, ancillary services, and additional procedures performed at the same time. Prior Authorization rules still apply.

SUMMARY OF BENEFITS PPO HDHP SILVER	PPO HDHP SILVER	
	In-Network	Out-of-Network
Deductible • Members must pay all costs from providers up to the deductible amount before this plan begins to pay. • If member has other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall deductible.	$3,000 Individual $6,000 Two-party $6,000 Family	$4,500 Individual $9,000 Two-party $9,000 Family
Out-of-Pocket Maximum • The out-of-pocket limit is the most a member could pay in a year for covered services. • If a member has other family members on this plan, they must meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.	$8,500 Individual $10,150 Two-party $10,150 Family	$12,000 Individual $24,000 Two-party $24,000 Family
Member Coinsurance	30%	50%
Primary Care (Visit to treat an injury or illness excluding Preventive and X-rays)	30% coinsurance after deductible	50% coinsurance after deductible
Preventive Care/Screening/Immunization [1] • Routine Physical • Annual women's exam • Annual men's exam including PSA • Related laboratory tests including x-rays (includes routine pap tests, cholesterol tests, urinalysis, mammogram, colonoscopy, etc.) • Well childcare including vision and hearing screenings (through age 21) • Immunizations • Health education and counseling (including smoking/tobacco cessation education) • Family planning	$0	50% coinsurance after deductible
Specialist Visit	30% coinsurance after deductible	50% coinsurance after deductible
Urgent Care Facility	30% coinsurance after deductible	50% coinsurance after deductible
Emergency Room Services [4]	30% after deductible (In-Network deductible applies)	30% after deductible (In-Network deductible applies)
Ambulance (Emergency Ground or Air Transport)	30% after deductible, coinsurance (In-Network deductible applies)	30% after deductible, coinsurance (In-Network deductible applies)
Virtual Care Services All Medical and Behavioral Virtual Care Services (Telephonic or Video) • Primary Care • Specialty Care • Urgent Care	$0	50% after deductible
Prescription Drugs	Administered by Express Scripts. Call Express Scripts at 1-866-447-5521	
Laboratory Outpatient and Professional Services	30% coinsurance after deductible	50% coinsurance after deductible
X-ray and Diagnostic Imaging	30% coinsurance after deductible	50% coinsurance after deductible
Imaging (CT/PET Scans, MRIs) [2]	30% coinsurance after deductible	50% coinsurance after deductible

SUMMARY OF BENEFITS PPO HDHP SILVER	PPO HDHP SILVER	
	In-Network	**Out-of-Network**
Maternity Services	30% coinsurance after deductible	50% coinsurance after deductible
Routine nursery care for newborn • If mother is covered under the plan, baby is covered from birth but must be enrolled in the medical plan as quickly as possible but no later than 30 days from date of birth.	30% after deductible	50% after deductible
Transplant [5] Coverage for human organ transplants • Case Management required • Refer to Summary Plan Description for complete details on transplant coverage. Maximums apply to covered travel and lodging services.	30% coinsurance after deductible	Not covered
Speech, Occupational and Physical Therapy [3]	30% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility [3]	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery Physician/Surgical Services [2] **and Facility Fees** (e.g., Ambulatory Surgery Center)	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Mental/Behavioral Health and Substance Use Disorder Services	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Facility Fee – Mental Health	30% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospital Services [2] (excluding Mental Health/Substance Use Disorder)	30% coinsurance after deductible	50% coinsurance after deductible
Inpatient Mental Health/Substance Use Disorder (SUD)	30% coinsurance after deductible	50% coinsurance after deductible
Allergy Testing and Treatment	30% coinsurance after deductible	50% coinsurance after deductible
Allergy Injections only	30% coinsurance after deductible	50% coinsurance fter deductible
Allergy Extraction Preparation	30% coinsurance after deductible	50% coinsurance after deductible
Acupuncture [3] (limited to 25 visits combined/plan year)	30% after deductible	50% after deductible
Chiropractic [3] (limited to 25 visits combined/plan year)	30% after deductible	50% after deductible
Naprapathic Services, Massage Therapy [3] (limited to 25 visits combined / plan year). No copay applies for behavioral health for HMOs and PPO in-network	30% after deductible	50% after deductible
Autism Spectrum Disorders [2] • Diagnosis and treatment of autism spectrum disorder • Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder	30% coinsurance after deductible	50% coinsurance after deductible

SUMMARY OF BENEFITS PPO HDHP SILVER	PPO HDHP SILVER	
	In-Network	Out-of-Network
Cardiac Rehab [2] and Pulmonary Rehab [2]	30% coinsurance after deductible	50% coinsurance after deductible
Chemotherapy and/or Radiation Therapy	30% coinsurance after deductible	50% coinsurance after deductible
Dialysis	30% coinsurance after deductible	50% coinsurance after deductible
Diabetes Coverage (office visit and diabetes education)	30% coinsurance after deductible	50% coinsurance after deductible
Diabetic supplies, equipment, appliances, and services [2] • Prescribed by the attending physician • Purchased through a Durable Medical Equipment (DME) provider	30% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME), orthopedic appliances, prosthetics, and functional orthotics	30% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids (to include repair, replacement and associated testing)	30% after deductible, up to $2,500 per ear every 36 months	50% after deductible, up to $2,500 per ear every 36 months
Hospice [2] • Bereavement Counseling (Limited to 3 sessions during the hospice benefit period) • Respite Care (Lifetime Maximum of 2 sessions of up to 10 days for each Hospice benefit period)	30% after deductible	50% after deductible
Home Health Care [2]/ Home Intravenous Service [2] Prescribed home physician services, nursing care and rehabilitative therapy	30% coinsurance after deductible	50% coinsurance after deductible

[1] The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires health plans to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to the member when the services are provided by an In-Network Participating Provider. Although these services are covered at no charge, the provider may charge a copayment for other services provided during the office visit. Additionally, some covered Family Planning services continue to require member cost-sharing. If you have questions regarding the Preventive Care Services that are covered under this plan, including Family Planning Services, or your cost for these services, please refer to your Evidence of Coverage/Summary Plan Description, or contact Presbyterian Health Plan at the phone number listed on your ID card. These services must be Medically Necessary as defined by the Summary Plan Description.

[2] Pre-Admission Review and/or Prior Authorization is required; $250 penalty, reduction or denial may apply to facility and provider services if the required Pre-Admission Review and/or Prior Authorization is not obtained.

[3] This benefit includes an annual visit limitation. See your Summary Plan Description for more information.

[4] The Emergency Services coinsurance is waived if an inpatient hospital admission results; then the hospital admission deductible and coinsurance applies.

[5] Transplants are covered In-Network only by Tier I or Tier II providers. Case Management Services for transplant patients must be obtained from Presbyterian Health Plan at the phone number listed on your ID card.

[6] Patients are responsible for copay or deductible and coinsurance related to place of service, ancillary services, and additional procedures performed at the same time. Prior Authorization rules still apply.

For information on Presbyterian Health Plan's Nondiscrimination Notice, go to **https://www.phs.org/nondiscrimination**.