PRESELECT $5000/5000/80%/$20 Standard Vision
MHPAEA
SMALL GROUP
PPO
(IIP10275)

The following *Schedule of Benefits* is a summary that describes the Co-insurance and or Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by PIC. Benefits may have limits and certain services are excluded altogether. For a more complete description, please refer to Sections of the *Group Subscriber Agreement* that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

Underwritten by

Presbyterian Insurance Company, Inc. (PIC)

Pres Elect MHPAEA Small Group (IIP10275) Benefits and Coverage	In-network Limits	Out-of-network Limits
ANNUAL CALENDAR YEAR DEDUCTIBLE (Deductible must be met before payments are made)	Individual: $5,000 Family: x3 (Individual)	Individual: $10,000 Family: x3 (Individual)
ANNUAL OUT-OF-POCKET MAXIMUM (Includes Co-insurance only- does **not** include Deductible, Copayments, penalty amounts, charges above Reasonable and Customary, prescription drug Copayments, Medical Drug Copayments or non-Covered charges including charges incurred after the benefit maximum has been reached) (PIC pays 100% of Covered charges after the Out-of-Pocket maximum is met)	Individual: $5,000 Family: x3 (Individual)	Individual: $10,000 Family: x3 (Individual)
PRE-EXISTING LIMITATION (Does not apply to pregnancy, newborns, and newly adopted children)	• No pre-existing limitation for children under age 19 • No pre-existing if prior (creditable) coverage • New Hires: 6/6 • Late Enrollees: 6/18	
MAXIMUM LIFETIME BENEFIT (Does not include Family, Infant and Toddler (FIT) Program services and Autism Spectrum Disorder)	Unlimited	
AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT MAXIMUM LIFETIME BENEFIT	$200,000 per member per lifetime (Does not apply to Plan Lifetime Maximum). Beginning January 1, 2011 the maximum benefit shall be adjusted manually January 1 to reflect any change from the previous year in the medical component of the then-current price index for all urban consumers published by the Bureau of Labor Statistics of the United States Department of Labor.	
BENEFITS AND COVERAGE	**In-Network Co-insurance**	**Out-of-Network Co-insurance**
PHYSICIAN SERVICES including: Non-specialist/Specialist office visits	$20[2] Copayment per visit - Adult $10[2] Copayment per visit – Child (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit)	40% Co-insurance
Home visits (if Medically Necessary)	20% Co-insurance	40% Co-insurance
Outpatient surgery (In-Physician's office)	20% Co-insurance	40% Co-insurance
Allergy services		
Testing	20% Co-insurance	40% Co-insurance
Serum (extracts)	20% Co-insurance	40% Co-insurance
Injections	20% Co-insurance (waived if nursing visit only)	40% Co-insurance
Infertility Services	**Not Covered**	**Not Covered**
On-campus Student Health Center	20% Co-insurance	40% Co-insurance
Hospital and Skilled Nursing Care Visits	20% Co-insurance	40% Co-insurance

[1]Benefit Certification will be required [2]Not subject to Deductible
Refer to the Group Subscriber Agreement for a more complete description of benefits.

Pres Elect MHPAEA Small Group (IIP10275) Benefits and Coverage	In-network Co-insurance	Out-of-network Co-insurance
HOSPITAL SERVICES – Inpatient[1] Coverage includes: • Room and board • Newborn delivery and other Hospital obstetrical services • In-hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient services • Detoxification • Administration of blood/blood components	20% Co-insurance	40% Co-insurance
MEDICAL SERVICES – Outpatient[1] Home/Outpatient Sleep studies (Limited to $1,000 per member per calendar year, in-network and out-of-network combined) Laboratory tests Medical Drugs [1] - Provided or Administered in an Outpatient setting Observation (*Benefit Certification required if Observation greater than 24 hours)	20% Co-insurance 20% Co-insurance 0%[2] 20% Copayment[2] up to a maximum of $400 per injection and $2,500 per Calendar Year. Once the $2,500 Calendar Year maximum is met by the member, the plan pays 100% of allowed charges for the remainder of the Calendar Year. 20% Co-insurance	40% Co-insurance 40% Co-insurance 40% Co-insurance 20% Copayment[2] up to a maximum of $400 per injection 40% Co-insurance
RECONSTRUCTIVE SURGERY[1]	20% Co-insurance	40% Co-insurance
EMERGENCY ROOM CARE Including trauma services	$100[2] Copayment per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit). (Waived if admitted into a Hospital, then Hospital benefit applies)	$100[2] Copayment per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit). (Waived if admitted into a Hospital, then Hospital benefit applies.) Initial treatment only. (Follow-up services and treatment are subject to deductible and 40% Co-insurance)
URGENT CARE	$50[2] Copayment per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to Deductible and 20% Co-insurance)	$50[2] Copayment per visit (Copayment is for the office visit **only**. All other services received during the office visit are subject to Deductible and 20% Co-insurance.) Initial treatment only. (Follow-up services and treatment are subject to deductible and 40% Co-insurance)

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Refer to the Group Subscriber Agreement for a more complete description of benefits

Pres Elect MHPAEA Small Group (IIP10275) Benefits and Coverage	In-network Co-insurance	Out-of-network Co-insurance
AMBULANCE SERVICES including:		
Emergency or high risk • Ground ambulance • Air ambulance	20% Co-insurance	20% Co-insurance
Inter-facility transfer Services • Ground ambulance • Air ambulance	0%[2]	0%[2]
CLINICAL PREVENTIVE SERVICES Well child care including vision and hearing screening Preventive physical exam Adult and child immunizations Office based health education Family planning services Cytologic screening (Pap Smear) Human Papillomavirus (HPV) Screening HPV Vaccine for females Mammography Colonoscopy	0%[2] Co-insurance	40% Co-insurance
WOMEN'S HEALTH CARE		
Gynecological care	$20[2] Copayment per visit - Adult $10[2] Copayment per visit – Child (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit)	40% Co-insurance
Implantable contraceptive Devices	20% Co-insurance	40% Co-insurance
In office obstetrical/maternity care/prenatal & postnatal care	$20[2] Copayment per visit up to a maximum of $200 per pregnancy. (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Services Outpatient benefit)	40% Co-insurance
Specialist (Perinatologist)	20% Co-insurance	40% Co-insurance
Newborn delivery and other hospital Obstetrical services[1]	20% Co-insurance	40% Co-insurance
DIABETES SERVICES Office visit and Diabetes Education	$20[2] Copayment per visit - Adult $10[2] Copayment per visit – Child (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit)	40% Co-insurance

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Pres Elect MHPAEA Small Group (IIP10275) Benefits and Coverage	In-network Co-insurance	Out-of-network Co-insurance
DIABETES SERVICES *Continued from previous page*		
Certified Diabetes Educators Telephonic visits	0%[2] Co-insurance	40% Co-insurance
Diabetes Supplies[1] (Purchased through a Durable Medical Equipment provider)	20% Co-insurance	40% Co-insurance
Diabetes Supplies[1] [2] (Purchased through a Participating Pharmacy)	See the Prescription Drug Rider purchased by your Group for Member Deductible and Copayment	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area)
COVERED MEDICATIONS – Outpatient[1][2] Listed on the PIC Preferred Drug List (Purchased at a Participating Pharmacy, unless due to an emergency occurring outside the PIC Service Area)		
• Medically Necessary Nutritional Supplements for prenatal care • Insulin and diabetic oral agents • Diabetic supplies (Purchased through a Participating Pharmacy) • Smoking cessation drugs (Limited to two 90-day courses of treatment per Calendar Year) • Contraceptive Drugs	See the Prescription Drug Rider purchased by your Group for Member Deductible and Copayment	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area)
• Immunosuppressive drugs following transplant surgery[1][2]	20% Copayment[2] up to a maximum of $400 per injection and $2,500 per Calendar Year.	
• Specialty Pharmaceuticals	20% Copayment[2] up to a maximum of $400 per injection and $2,500 per Calendar Year.	
• Special Medical Foods[1][2]	20% Co-insurance	
For plans with "Covered Medication" coverage only this plan is considered Creditable per Medicare part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov. If your employer has purchased the Optional Prescription Drug Rider please refer to that rider for Medicare Part D Creditable/Non-Creditable status.		
PRESCRIPTION DRUGS Prescription Drugs (Retail/Mail Order) – Outpatient	See the Prescription Drug Rider purchased by your Group for Member Deductible and Copayment	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area)
MENTAL HEALTH SERVICES[1]		
• Outpatient[1]	$20[2] Copayment per visit - Adult $10[2] Copayment per visit – Child (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit)	40% Co-insurance

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Refer to the Group Subscriber Agreement for a more complete description of benefit

Pres Elect MHPAEA Small Group (IIP10275) Benefits and Coverage	In-network Co-insurance	Out-of-network Co-insurance
MENTAL HEALTH SERVICES *Continued from previous page*		
• Inpatient[1]	20% Co-insurance	40% Co-insurance
• Partial Hospitalization[1] (Waived if immediately following an inpatient hospital discharge)	20% Co-insurance	40% Co-insurance
ALCOHOL AND SUBSTANCE ABUSE SERVICES[1]		
Detox and Rehabilitation		
• Outpatient	$20[2] Copayment per visit - Adult $10[2] Copayment per visit – Child (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit)	40% Co-insurance
• Inpatient[1]	20% Co-insurance	40% Co-insurance
• Partial hospitalization[1] (Waived if immediately following an inpatient hospital discharge)	20% Co-insurance	40% Co-insurance
REHABILITATION AND THERAPY SERVICES[1]		
Dialysis/Plasmapheresis/Photopheresis	20% Co-insurance	40% Co-insurance
Cardiac Rehabilitation	20% Co-insurance	40% Co-insurance
Pulmonary Rehabilitation	20% Co-insurance	40% Co-insurance
Short-term Rehabilitation (Physical and Occupational Therapy up to two months per condition)		
• Inpatient	20% Co-insurance	40% Co-insurance
• Outpatient	20% Co-insurance	40% Co-insurance
Speech and Hearing Therapy[1] (up to two months per condition)	20% Co-insurance	40% Co-insurance
Cardiac Rehabilitation, Pulmonary Rehabilitation, Short Term Physical Occupational Therapy, and Speech and Hearing Therapy have a combined limit of $2,500 per member per Calendar Year for outpatient services received from both In-network and Out-of-network (combined).		
TRANSPLANTS[1]	20% Co-insurance	**Not Covered**
COMPLEMENTARY THERAPIES (Limited)	20% Co-insurance	
Acupuncture treatment (maximum $1,500 per member per Calendar year combined with Chiropractic services and covered Biofeedback)	20% Co-insurance	**Not Covered**
Chiropractic services (maximum $1,500 per member per Calendar year combined with Acupuncture services and covered Biofeedback)	20% Co-insurance	**Not Covered**
Biofeedback for specific conditions (maximum $1,500 per member per Calendar year combined with Chiropractic services and Acupuncture services)	20% Co-insurance	**Not Covered**
SKILLED NURSING FACILITY[1] (Up to 60 days per Calendar Year)	20% Co-insurance	40% Co-insurance
HOME HEALTHCARE SERVICES/HOME INTRAVENOUS SERVICE[1]	20% Co-insurance	40% Co-insurance
HOSPICE CARE[1]	20% Co-insurance	40% Co-insurance

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Refer to the Group Subscriber Agreement for a more complete description of benefits

Pres Elect MHPAEA Small Group (IIP10275) Benefits and Coverage	In-network Co-insurance	Out-of-network Co-insurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES[1] ($5,000 per Calendar Year Maximum, In-network and Out-of-network combined) (Diabetic supplies do not count toward the Calendar Year Maximum benefit.) Hearing Aids (for school aged children under 18 or 21 years of age if still attending high school).	20% Co-insurance Up to $2,200 every 36 months "per hearing impaired ear".	40% Co-insurance
EYEGLASSES AND CONTACT LENSES Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus[1] • Refraction eye Exam associated with post cataract surgery or Keratoconus correction	20% Co-insurance	40% Co-insurance
DENTAL SERVICES(LIMITED)CMJ/TMJ	20% Co-insurance	40% Co-insurance
FAMILY, INFANT AND TODDLER PROGRAM **Family, Infant and Toddler Program (FIT):** Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.	Applicable Co-insurance as defined by service Co-insurance shown on the *Schedule of Benefits*, No Co-insurance $3,500 per Member per Calendar Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits	
AUTISM SPECTRUM DISORDER[1] Treatment through or provided by: Non-specialist/Specialist Applied Behavioral Analysis (ABA)[1]	$20[2] Copayment per visit - Adult $10[2] Copayment per visit – Child (Copayment is for the office visit **only**. All other services received during the office visit are subject to the Medical Service Outpatient benefit)	40% Co-insurance
Outpatient Physical Therapy	20% Co-insurance	40% Co-insurance
Outpatient Occupational Therapy	20% Co-insurance	40% Co-insurance
Outpatient Speech Therapy	20% Co-insurance	40% Co-insurance
Short Term Physical Occupational Therapy, and Speech and Hearing Therapy are limited as listed under Rehabilitation Therapy Services previously in this *Schedule of Benefits*.		
Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school.	Up to $36,000 per member per Calendar Year combined In-network and Out-of –network. $200,000 per member per lifetime combined In-network and Out-of-network. (Not applicable to any other Annual Limits) Benefit Certification penalty does not apply towards Calendar Year maximum. Benefit Certification penalty does not apply towards Lifetime Maximum.	

[1]Benefit Certification will be required [2]Not subject to Deductible
Refer to the Group Subscriber Agreement for a more complete description of benefits

Your VSP Vision Benefits

Why enroll in a VSP® Vision Care plan? Because we'll help keep you and your eyes healthy with personalized care from a doctor you can trust.

You'll like what you see with VSP:

- **Personalized Care.** Our doctors take the time to get to know you and your eyes. They'll look for vision problems and signs of other health conditions too.
- **Doctor Network.** You'll find the VSP doctor who's right for you at **vsp.com/advantage** or by calling us at **800.877.7195**. Our doctors offer flexible hours, a variety of office settings, and eyewear choices you'll love.
- **Value and Savings.** You'll get great savings on your eye exam and eyewear, and discounts on laser vision correction.
- **Satisfaction Guaranteed.** You'll be 100% happy or we'll make it right.

Visit the Eyecare Discovery Center® at **vsp.com** for eye health articles, videos, and interactive games.

Enroll today. You'll be glad you did.

Once enrolled, simply tell your VSP doctor you're a member. We'll handle the rest.

Contact VSP. | **vsp.com** **800.877.7195**

VSP® Vision care for life

Presbyterian Insurance Company (PIC), Inc
And
Vision Service Plan Insurance Company (VSP) provide you an affordable eyecare plan

Your Coverage with a VSP Doctor

Doctor Network.....VSP Choice

****WellVision Exam®** focuses on your eye health and overall wellness

- $10.00 copayment..... ***every 12 months***

Extra Discounts and Savings

Glasses and Sunglasses

- *Average 20-25% savings on all non-covered lens options*
- *20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam*

Contacts

- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction

- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

**Exam.....*A maximum of $45 per 12 months*

VSP guarantees service from VSP Select Network doctors only.

Please provide your Presbyterian ID# to the VSP Network doctor.

***Underwritten by Presbyterian Insurance Co, Inc*

All vision benefits administered by Vision Services Plan (VSP) Insurance Company

[MPC081036]

EXCLUSIONS FOR PRES ELECT MHPAEA SMALL (IIP10275):

Any exclusion listed would not be applicable if Covered under the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services. Refer to your Group Subscriber Agreement for details.

- **Alternative/complementary therapies**, except as specified in the *Group Subscriber Agreement* (GSA).
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the *Group Subscriber Agreement* (GSA).
- **Athletic trainers.**
- **Autopsies** and/or transportation costs for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.
- **All other benefits and services not specifically listed as Covered in the Benefits Section shall be excluded.**
- **Biofeedback**, except as specified in the *Group Subscriber Agreement* (GSA).
- **Cancer Clinical Trials** are limited and must be provided for in the State of New Mexico in accordance with the provisions set forth in the *Group Subscriber Agreement* (GSA). Refer to your *Group Subscriber Agreement* (GSA) for details.
- **Care for conditions which State or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled and for which facilities are reasonably available to the Member.
- **Charges that are determined to be unreasonable by PIC.**
- **Charges above Reasonable and Customary charges**.
- **Circumcisions** performed other than during the newborn's Hospital stay, unless Medically Necessary.
- **Clothing** or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not.
- **Co-dependency treatment.**
- **Convenience items.**
- **Cosmetic Surgery**, **treatments, devices, orthotics, and medications**, including treatment of hair-loss.
- **Costs for extended warranties** and premiums for other insurance coverage.
- **Counseling –** sex, pastoral/spiritual, and bereavement counseling.
- **Court ordered evaluation or treatment**, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.
- **Custodial or domiciliary care**.
- **Dental care** and dental x-rays, except as provided in the *Group Subscriber Agreement* (GSA).
- **Dental implants**.
- **Disposable medical supplies**, except when provided in a Hospital or Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics –** additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacements due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Elective abortions** after the 24th week of pregnancy.
- **Elective Home Birth** and any prenatal or postpartum services connected with an elective home birth.
- **Emergency facility** used for non-emergent services.
- **Experimental or investigational**, as determined by PIC, drugs, medicines, treatments, or procedures.
- **Extracorporeal shock wave therapy** involving the musculoskeletal system.
- **Eye movement therapy**.
- **Eye refractive procedures** including radial keratotomy, laser procedures, and other techniques.

EXCLUSIONS FOR PRES ELECT MHPAEA SMALL (IIP10275):

- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the *Group Subscriber Agreement* (GSA).
- **Foot care (routine)**, except as provided in the *Group Subscriber Agreement* (GSA).
- **Foot orthotics** functional and/or customized except as described in the *Group Subscriber Agreement* (GSA).
- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses**.
- **Hearing aids** and the evaluation for the fitting of hearing aids except for school aged children under 18 years old (or under 21 years of age if still attending high school).
- **Hospice benefits are not available for the following services**: food, housing, and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under Durable Medical Equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling.
- **Hypnotherapy** except as part of anesthesia preparation or chronic pain management.
- **Infant formula**.
- **Infertility services.**
- **In-vitro, GIFT and ZIFT fertilization**.
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife.
- **Malocclusion treatment,** if part of routine dental care and orthodontics.
- **Massage Therapy**, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program.
- **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Member or when the transplant procedure is not covered.
- **New medications** for which the determination of criteria for Coverage has not yet been established by PIC's Pharmacy and Therapeutics Committee.
- **Nutritional supplements** except as outlined in the *Group Subscriber Agreement (GSA*).
- **Organ transplants (Non-human),** except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures**.
- **Orthodontic appliances** and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Over-the-counter medications except as specified in the *Group Subscriber Agreement* (GSA).**
- **Personal or comfort items, services or treatments**.
- **Photopheresis** for all conditions other than mycosis fungoides.
- **Physical examinations,** vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.
- **Prescription/Medical Drugs (Outpatient),** except as described in this *Schedule of Benefits* and the *Group Subscriber Agreement* (GSA) and as described in the Prescription Drug Rider.
- **Prescription Drugs** (as listed as Covered in this *Schedule of Benefits* or the Prescription Drug Rider and the *Group Subscriber Agreement*) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available.
- **Prescription Drugs/Medical Drugs requiring a Benefit Certification when Benefit Certification was not obtained**.
- **Prescriptions** purchased at a Non-Participating Pharmacy, unless required due to an emergency occurring outside of the PIC Service Area**.**
- **Prescription Drugs,** compounded medications.
- **Prescription Drug replacements** due to loss, theft or destruction.
- **Private duty nursing.**

EXCLUSIONS FOR PRES ELECT MHPAEA SMALL (IIP10275):

- **Psychological** testing when not Medically Necessary.
- **Residential Treatment Centers** unless for treatment of Alcohol/Substance Abuse.
- **Reversals of voluntary sterilization**.
- **Services for which the Member is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member.
- **Services requiring Benefit Certification** when Benefit Certification was not obtained.
- **Sex transformation surgery and drugs** relating to sex transformations.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics except for penile prosthesis as provided in the *Group Subscriber Agreement* (GSA).
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler program. Refer to the *Group Subscriber Agreement* (GSA) for more information.
- **Special Medical Foods,** except as listed as Covered in the *Group Subscriber Agreement* (GSA) for Genetic Inborn Errors of Metabolism.
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- "**Telephone visits** and electronic mail (e-mail)" by Physician or "consultation" by telephone for which a charge is made to the patient except for Members that have been diagnosed with diabetes.
- **Transportation costs** for deceased Members.
- **Travel and lodging** expenses, except as provided in the *Group Subscriber Agreement* (GSA).
- **Vision Care (routine) and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the *Group Subscriber Agreement* (GSA).
- **Visual training**.
- **Vocational Rehabilitation services and Long-Term Rehabilitation services**.
- **Weight reduction or control treatments and medications**, except for Medially Necessary treatment for morbid obesity. (Medications are Covered only if the Prescription Drug Rider is included.)
- **Work-related accidents** or injuries or occupational illness or disease if the Member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists.

Refer to the Group Subscriber Agreement for a more complete description of Exclusions & Limitations.

This Schedule of Benefits and services is subject to the provisions of the contract and cannot modify or affect the Group Subscriber Agreement in any way; nor shall you accrue rights because of any statement in or omission from this schedule.

Plan ID – IIP10377 *(for internal use)*