Central New Mexico Community College PPO Medical Plan

EFFECTIVE: January 1, 2022

Offered by Central New Mexico Community College
Administered by Presbyterian Health Plan, Inc.

MPC042219

WELCOME

This benefit booklet describes the medical benefits offered through the Central New Mexico Community College (CNM).

Our medical plans are self-insured. This means CNM is responsible for the design of the plan and the setting of contributions. We set the contribution rates to be adequate to pay for the claims we all incur. When our claims exceed the contributions, the contribution rates have to go up. We pay less than 10% of the contribution towards the medical plan administration (claims payment, customer service, Provider networking, ID cards, booklets). The balance pays for the cost of our medical care.

All medical plans offer FREE In-Network preventive care. Please take advantage of this benefit after you enroll. Early diagnosis plays a big part in the eventual outcome of any health condition.

This booklet is intended to provide you with an easy-to-understand explanation of the Plan effective January 1, 2022. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this booklet and the claims administrative procedures of our Third-Party Administrator, Presbyterian Health Plan, Inc., or if any provision is not covered or only partially covered, the terms of the Professional Services Agreement will govern in all cases.

This booklet does not imply a contract of employment. The Central New Mexico Community College reserves the right to terminate, modify, or change this Plan or any provision of this Plan at any time.

It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family.

INTRODUCTION

The Central New Mexico Community College provides group healthcare coverage through the Preferred Provider Organization (PPO) Medical Plan (Plan) administered by Presbyterian Health Plan, Inc.

This booklet is your *Member Benefit Booklet*. It describes the benefits and limitations of the Plan. It explains how to file claims (if applicable), how to request reconsideration of a claim, or file for an adjustment of a benefit payment.

You should know several basic facts as you read this booklet:

- Providers are Physicians, Hospitals, and other healthcare Professionals or facilities that provide Healthcare Services.
- Preferred Providers have contractual agreements with Presbyterian Health Plan, Inc., and allow lower Out-of-pocket expenses and additional benefits for covered persons.
- Non-preferred Providers do not have contractual agreements with Presbyterian Health Plan, Inc. which may increase the Out-of-pocket expenses and limit benefits for covered persons.

This PPO Plan allows you to choose, at the time you receive services, the level of benefits that will apply. **You receive the highest benefit level with the lowest cost to you when you obtain services from a Preferred Provider.** *The Presbyterian Health Plan Provider Directory* lists the Preferred Providers. The Provider Directory is available through the Presbyterian website at www.phs.org or you can obtain one by contacting the Presbyterian Customer Service Center at (505) 923-7752 or toll-free at 1-866-670-0600. TTY users may call 711.

Additionally, Presbyterian Health Plan now contracts with National PPO Network Provider, a National Preferred Provider organization with over 3,500 acute care Hospitals and 400,000 practitioners. If you live or are traveling outside the State of New Mexico, and require medical attention, we encourage you to see National PPO Network Provider practitioners and facilities. Nation PPO Network Providers provide care to Presbyterian Health Plan Members at discounted rates, which help keep the cost of medical care down. Additionally, you cannot be charged for any difference between what Presbyterian Health Plan pays the Provider and what the Provider charges beyond your appropriate Copay and/or Deductible and Coinsurance (see Section 1 - How the Plan Works). The National PPO Network Provider Directory is available through their website at www.multiplan.com or you can contact the Presbyterian Customer Service Center, Monday through Friday from 7:00 a.m. and 6:00 p.m. at (505) 923-7752 (in Albuquerque), or **toll-free** within New Mexico at 1-866-670-0600. TTY users may call 711.

Please take the time to read this booklet carefully before placing it in a safe place for future reference. If you have any questions regarding this booklet, please call the Presbyterian Customer Service Center, Monday through Friday from 7:00 a.m. and 6:00 p.m. at (505) 923-7752 or **toll-free** within New Mexico at 1-866-670-0600 (Ask-PRES). It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under this Plan.

SECTION 1 – HOW THE PLAN WORKS

HOW THE PLAN WORKS

Your group healthcare plan is a Preferred Provider Organization or "PPO." This PPO plan allows you to choose, at the time you receive services, the level of benefit that will apply (In-network or Out-of-network). You receive the highest benefit level with the lowest cost to you when you obtain services from an In-network Provider.

IN-NETWORK PROVIDERS

As a Member of this PPO, for payment to be made you will generally **not** have claims to file or papers to fill out for medical services obtained from In-network Providers. In-network Providers will bill Presbyterian Health Plan directly. Most doctor visits and Hospital Admissions do, however, require Coinsurance and/or Copayments at the time of service. Coinsurance is the percentage of covered charges that you must pay for Covered Services after the Deductible has been met. The amount of your Coinsurance and/or Copayment for each service can be found in the *Summary of Benefits* section of this document. The Coinsurance will be applied to the Total Allowable Charges or billed charges, whichever is less, for the particular procedure allowed by the Plan.

OUT-OF-NETWORK BENEFITS

When you obtain care from a Practitioner/Provider who is not in our network (Out-of-network Practitioner/Provider), the Out-of-network Covered Benefits will apply. As shown in the Summary of Benefits and Coverage, the benefit levels are lower and your Cost Sharing (Copayments, Deductibles and Coinsurance) amounts are higher.

Additionally, when you receive care from Out-of-network Practitioners/Providers, our payments to them for Covered Services will be limited to Medicare allowable. You will be responsible for any amount due above the Medicare allowable, in addition to any applicable Cost Sharing amount. Medicare allowable is defined in the Glossary of Terms Section.

Out-of-network Practitioners/Providers may require you to pay them in full at the time of service. You may have to pay them and then file your claim for reimbursement with us.

Please refer to your Summary of Benefits and Coverage, the Benefit Section and the Exclusions Section for a complete listing of Covered and Excluded services.

For Hospital admissions and other services from Out-of-network Practitioners/Providers that require Prior Authorization, you are responsible for ensuring that proper Prior Authorization has been obtained before being admitted to the Hospital or before receiving those services that require Prior Authorization from Out-of-network Practitioners/Providers.

If you are referred to an Out-of-network Practitioner/Provider, services from that Out-of-network Practitioner/Provider are subject to the Out-of-network benefit levels shown in the Summary of Benefits and Coverage.

DIALYSIS SERVICES:

The Plan pays 100% of the Medicare Composite Rate Payment Methodology for dialysis services and 100% of the Medicare Average Sales Price Fee Schedule for ESRD drugs; if no allowable is found, then the Plan pays 60% of billed charges for items/services not included in the Medicare Composite Rate.

OUT-OF-NETWORK PROVIDERS

Out-of-network Providers do not have contractual agreements with Presbyterian Health Plan. Out-of-network services, as shown in the *Summary of Benefits*, apply when you obtain care from an Out-of-network Provider**.**

If you choose to receive care from Out-of-network Providers, payments by Presbyterian Health Plan for Covered Services will be **limited** to Medicare allowable Charges (the only exception will be for emergency services). You will be responsible for any balance due above the Medicare allowable Charges, in addition to any applicable Deductible or Coinsurance. Out-of-network Providers may require you to pay them directly at the time of service; you will then have to file your claim for reimbursement with Presbyterian Health Plan. Refer to the Section 5 Filing Claims, for more information on submitting such a claim.

Some services are **not covered** when received from Out-of-network Providers. Please refer to your *Summary of Benefits* and throughout this document for a complete listing of Covered Services.

WHAT IS PRIOR AUTHORIZATION?

Prior Authorization determines only the medical necessity of a procedure or an Admission and an allowable length of stay. **Prior Authorizations** do not guarantee payment, and do not validate eligibility (for example, to receive non-specified services from a particular Provider). Benefit payments are based on your eligibility and benefits in effect at the time you receive services. **Services not listed as covered and services that are not Medically Necessary are not covered**.

The **Prior Authorization** requirements affect whether the Plan pays for your Covered Services. However, **Prior Authorization** does not deny your right to be admitted to any Hospital.

IMPORTANT: If you have Two-Party or Family Medical Coverage, **Prior Authorization** requirements apply to your family Members who are also covered persons.

WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION?

Certain procedures or services, as identified in the next subsection of this document, do require **Prior Authorization**. The responsibility for obtaining **Prior Authorization** is as follows:

- In-network Provider - When accessing services from an In-network Provider, the In-network Provider is responsible for obtaining **Prior Authorization** from Presbyterian Health Plan before providing these services to you.

- Out-of-network Provider or National PPO Network Providers - When accessing services from an Out-of-network Provider or a National PPO Network Provider, you are responsible for obtaining **Prior Authorization** from Presbyterian Health Plan before obtaining services from an Out-of-network or National PPO Network. If **Prior Authorization** is **not** obtained when required, then the benefits will be reduced as listed on the *Summary of Benefits*.

PRIOR AUTHORIZATION – INPATIENT

If your In-network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, your In-network Provider is responsible for any **Prior Authorization** requirement for Inpatient Admissions. If an Out-of-network Provider or National PPO Network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, you are responsible for any **Prior Authorization** requirement for Inpatient Admissions. If **Prior Authorization** is not obtained, the Member will be responsible for a $300

penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*.

If Presbyterian Health Plan determines that the Admission was for a covered service, but hospitalization was not Medically Necessary, **no** benefits are paid for Inpatient room and board charges and these expenses do **not** apply toward the Out-of-pocket Maximum. Other Covered Services are paid as explained in the *Summary of Benefits* and Section 3 - Covered Services. If the Admission is not for a covered service, **no** payment is made.
Prior Authorization procedures also apply in the event you are transferred from one facility to another, you are readmitted, or when a newborn child remains hospitalized after the mother is discharged.

PRIOR AUTHORIZATION – OTHER MEDICAL SERVICES
Prior Authorization requirements are subject to change at the discretion of Presbyterian Health Plan with the approval of the Central New Mexico Community College. Contact our Customer Service Center at (505) 923-7752 or toll-free at 1-866-670-0600 to verify services requiring **Prior Authorization**.

In addition to **Prior Authorization** for all Inpatient services, **Prior Authorization** is required for the following services. For certain services, **Prior Authorization** may be requested over the telephone.
If **Prior Authorization** is not obtained for the following services, benefits will be reduced or denied for all related services. Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services:

- Clinical Trials (as specified in Section 3 – Covered Services)
- Detoxification (acute requiring medical intervention);
- Podiatric and Orthopedic Appliances;
- Rentals;
- Foot Orthotics;
- Home health care;
- Hospice;
- Hospital Admissions;
- Injectable over $100 and certain injectable received in the Provider's office;
- Medical Supplies greater than $1,000;
- Morbid Obesity Treatment;
- Positron Emission Tomography (PET) Scans;
- Reconstructive Surgery;
- Repair or replacement of non-rental DME;
- Selected Surgical Procedures including but not limited to; Blepharoplasty (surgery on the upper eyelid), Breast Reduction Surgery, Morbid Obesity Surgery, Vein Surgery;
- Skilled Nursing Facilities; and
- Transplants.

For National PPO Network Providers/Practitioners, you will be responsible for obtaining Prior Authorization when required. If you obtained Covered Services from a National PPO Network Provider/Practitioner and obtain Prior Authorization when required, benefits will be administered at the higher, In-Network level of benefits.

CASE MANAGEMENT PROGRAM

Presbyterian Health Plan's Case Management Program is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive hospitalization, or have complicated discharge planning needs so that cost-effective alternative care arrangements can be made. Special care arrangements are coordinated with the Physician and may include benefits for services that are not ordinarily covered. In addition, the case management program acts to assist the patient and Physician in complex situations and coordinates care across the healthcare spectrum.

FEDERAL AND STATE HEALTH CARE REFORM

PHP shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any changes in law, or the promulgation of any final rule or regulation which directly affects PHP's obligations under this Summary Plan Description will be deemed automatically amended such that PHP shall remain in compliance with the obligations imposed by such law, rule or regulation.

TRANSITION OF CARE

If you are a new Member and are in an ongoing course of treatment with an Out-of-network Provider, you will be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed 90 days). Similarly, if you are in an ongoing course of treatment with an In-network Provider and that Provider becomes an Out-of-network Provider, you will be allowed to continue care from this Provider for a transitional period of time. Application must be made within 30 days of the event. Please contact Presbyterian Health Plan's Health Services Department at 1-888-923-5757 for further information on Transition of Care.

COST SHARING FEATURES

The Plan shares the cost of your healthcare expenses with you. The following describes the different cost-sharing methods available, as detailed in the *Summary of Benefits.*

COPAYMENT

For most services obtained from an In-network Provider, you pay a Copayment and the Plan pays a portion of the remainder. The Copayment is stated as a set dollar amount. See the *Summary of Benefits* for all applicable Copayments.

CALENDAR YEAR DEDUCTIBLE (JANUARY 1 - DECEMBER 31)

Most services are subject to a Calendar Year Deductible. The amount of your Calendar Year Deductible can be found in the *Summary of Benefits*. This Deductible must be paid for by you each Calendar Year toward Covered Services **before** health benefits for that Member will be paid by the Plan (except for those services requiring only a Copayment).

For Single and Two-Party Coverage, each Member must meet the applicable individual Deductible as outlined in the Summary of Benefits. For Family Medical Coverage, an entire family meets their applicable Deductible when the total Deductible amount for all family Members reaches the applicable family amount indicated on the Summary of Benefits.

Under both Plans, the Deductible for In-Network provider services do not cross-apply to the Out-of-Network Deductible nor vice versa.

COINSURANCE

For most services, you will pay a Coinsurance. This is the amount of the covered healthcare expense that is partially paid by the Plan and partially paid by you on a percentage basis. This Coinsurance is in addition to the Calendar Year Deductible you are responsible for and continues to be your responsibility after the Calendar Year Deductible is met. See the *Summary of Benefits* for Coinsurance amounts.

OUT-OF-POCKET MAXIMUM

This Plan includes a Calendar Year Out-of-pocket Maximum amount to protect you from catastrophic health care expenses. After your Calendar Year Out-of-pocket Maximum is reached in a Calendar Year, the Plan pays 100%, for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts. Refer to the *Summary of Benefits* for the Calendar Year Out-of-pocket Maximum amounts.

The Calendar Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits*. Penalty amounts, non-covered charges, and any amounts over Medicare allowable charges are not included in the Out-of-pocket Maximum.

Under the Low Option Plan, amounts applied to your In Network Out-of-pocket Maximum are also applied to the Out-of-network Out-of-pocket Maximum, (until you're In Network Out-of-pocket Maximum is met), and vice versa.

Under the High Option, amounts applied to your In Network Out-of-pocket Maximum are not applied to the Out-of-network Out-of-pocket Maximum, nor are the amounts applied to your Out-of-network Out-of-pocket Maximum applied to the In-network Out-of-pocket Maximum.

FAMILY OUT-OF-POCKET MAXIMUM

An entire family meets the applicable Out-of-pocket limit when the total Out-of-pocket amount for all family Members reaches the applicable family Out-of-pocket Maximum indicated on the *Summary of Benefits*. The Summary of Benefits also illustrates the Two-Party and Family Out-of-pocket limits. Note: If a Member's individual Out-of-pocket Maximum is met, no more charges incurred by that Member may be used to satisfy the family Out-of-pocket Maximum.

The Calendar Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits*. Penalty amounts, non-covered charges and any amounts over Medicare allowable charges are not included in the Out-of-pocket Maximum.

If the Plan's Out-of-pocket Maximums change during the year, then the new amounts are in effect during that same Calendar Year. This means that if you had met your lower Out-of-pocket Maximums and then this Plan changes to higher Out-of-pocket Maximums, you do not continue to receive the 100% payment until the increase in the Out-of-pocket Maximum is met during the higher out-of-pocket period. If your Out-of-pocket Maximum amounts decrease, you do not receive a refund for any Out-of-pocket amounts applied during the higher Out-of-pocket period.

MAXIMUM OVERALL

There is no Lifetime maximum payment under the Plan. However, certain benefits are specifically limited and have maximum limits per Calendar Year or lifetime, as described in the *Summary of Benefits* and in Section 4– Limitations and Exclusions.

MEDICALLY NECESSARY SERVICES

Medically Necessary: A service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under the Plan, and is determined by Presbyterian Health Plan's medical director to meet all of the following conditions:

- it is medical in nature; and
- it is recommended by the treating Physician;
- it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternatives that are equally effective;
  - cost-effectiveness, when compared to the alternative services or supplies;
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- It is not for the convenience of the Member, the treating Physician, the Hospital, or any other healthcare Provider.

Presbyterian Health Plan determines whether a healthcare service or supply is Medically Necessary and, therefore, whether the expense is covered. (Note: If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in Section 5 – Filing Claims). The fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it Medically Necessary or make the expense a Covered Service, even though it is not specifically listed as exclusion.

HEALTH CARE FRAUD MESSAGE

Insurance fraud may result in cost increases for this healthcare Plan. The following describes ways that you can help eliminate healthcare fraud:

- Be wary of offers to "waive Copayments, Deductibles, or Coinsurance." These costs are passed on to you eventually.
- Be wary of "mobile health testing labs." Ask what the insurance company will be charged for the tests.
- Always review the explanation of benefits (EOB) you receive from Presbyterian Health Plan. If there are any discrepancies, call one of our Customer Service Center Representatives.
- Be very cautious about giving information about your insurance coverage over the telephone.

If you suspect fraud, please call the Presbyterian Fraud Hotline at (505) 923-5959 or 1-800-239-3147

SECTION 2 – ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES SUMMARY*

***This is a summary of the CNM Rules and Regulations. Complete Rules and Regulations are available by visiting www.phs.org/cnm. Rules and Regulations Supersede information contained in this summary.**

MEMBERSHIP INFORMATION

ELIGIBLE EMPLOYEE

You are eligible to participate in the Central New Mexico Community College Employees Benefits Program if you are actively at work and work the minimum qualifying number of hours established by your employer. In most cases, employees qualify for coverage because they work a minimum of 20 or more hours per week and are eligible upon hire. Regular full-time instructors are eligible upon hire and regular part time instructors who work the equivalent of 30 hours per week or more are eligible based on 12-month lookback period. Coverage starts first of month following 30 calendar days of employment.

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ELIGIBLE DEPENDENTS

You may apply to enroll your eligible dependents (spouse and children) to your CNM Group coverage if your dependents meet CNM's eligibility requirements. You will be required to present the original supportive documentation to CNM's benefits office to prove that your dependents meet CNM's eligibility requirements. A copy of the appropriate supportive documentation must accompany your application or change card (or be presented to CNM's benefits office, or uploaded, prior to your coverage going into effect); otherwise, your dependents will experience a delayed effective date of coverage.

As a new hire, your coverage goes into effect upon hire. Please provide the appropriate supportive documentation proving that your dependents are eligible for CNM coverage. In cases of changes in status, you are granted 30 days from the qualifying event to provide the appropriate supportive documentation. In either case, coverage for your dependents will go into effect the first day of the month following the day you turn in the appropriate supportive documentation to CNM's benefits office, or uploaded, (provided you applied timely and meet the 30-day timeline for supportive documentation). The effective date of coverage for your dependents will not be made retroactive to your effective date of coverage, except for newborns and adopted children who are enrolled timely. See details

NEWBORN	CHILDREN PLACED FOR ADOPTION OR ADOPTED
You are granted 30 days from the first of the month following your newborn's birth to provide appropriate supportive documentation to CNM's benefits office.	You are granted 30 days from the first of the month following your child's date of placement for adoption or adoption (*whichever comes first*) to provide appropriate supportive documentation to CNM's benefits office.
Coverage for a newborn begins on the newborn's date of birth, provided that you are enrolled in CNM family medical coverage. Any claims associated with your newborn, cannot be processed until you apply to enroll your newborn.	Coverage for an adopted child begins on date of placement or adoption (*whichever comes first*) provided that you are enrolled in CNM family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.
If you are not enrolled in CNM family medical coverage, your newborn will not be automatically covered from date of birth. You must apply to enroll your newborn within 30 days from the newborn's date of birth. If you miss this 30-day enrollment period, your newborn will not be eligible for coverage until January 1.	If you are not enrolled in CNM family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 30 days from date of placement or adoption (*whichever comes first*) in order for your child's coverage to be effective from date of placement or adoption. If you miss this 30-day enrollment period, your child will not be eligible for coverage until January 1.

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The following is a list of dependents that are eligible to participate in your CNM Group coverage. This list also specifies the supportive documentation required to prove your dependent's eligibility:

ELIGIBLE DEPENDENT	SUPPORTIVE DOCUMENTATION REQUIRED
Legal Spouse	Original official state publicly filed marriage certificate from the County Clerk's Office or from the Bureau of Vital Statistics (*chapel certificate is also acceptable*)
Domestic Partner	Notarized affidavit of domestic partnership
Child under the age of 26 as follows:	
•Natural Child or Stepchildren	Original official state publicly filed birth certificate from the Bureau of Vital Statistics (*hospital birth registration form is also acceptable*)
•Legally adopted child or a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support	Evidence of placement by a state licensed agency, governmental agency or a court order/decree (*notarized statement and power of attorney are not acceptable*)
•Child for whom you have legal guardianship	Legal Guardianship Document (*notarized statement and power of attorney documents are not acceptable*)
•Foster child living in the same household as a result of placement by a state licensed placement agency, provided that the foster home is appropriately licensed	Placement order AND foster home license
•Dependent child with qualified medical child support order	Medical Child Support Order
Child enrolled in the CNM Group Plan who reaches age 26 while covered under the CNM Group Plan, who is wholly dependent on the eligible employee for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment	Evidence of incapacity and dependency in the form of a physician statement indicating diagnosis and prognosis and application must be provided 31 days before the child reaches age 26 or within 30-days from the date the child becomes incapacitated **while covered under the CNM Group Plan** (*final determination is made by the insurance carrier*).

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INELIGIBLE DEPENDENTS

The following **ARE NOT ELIGIBLE** for CNA Group Coverage:

- Ex-spouses (*even if stipulated in a final divorce decree*)
- Dependents while in active military service
- Children left in the care of an eligible employee without evidence of legal guardianship
- Parents, aunts, uncles, brothers, sisters, or any other person not defined as eligible dependent under CNM Rules

ENROLLMENT REQUIREMENTS

You are required to provide Social Security numbers for you and your dependents to enroll in the CNM Group Plan. If you are in the process of applying for a social security number, you may turn in this proof to CNM's benefits office.

You may choose to apply to enroll in single coverage. If you choose to apply to enroll one eligible dependent, you must enroll ALL eligible dependents unless one of the following applies:

1. the eligible dependent for which you are requesting to exclude from a particular line of CNM coverage is covered for that particular line of coverage under another plan (individual, group, Medicaid, Medicare, VA, Indian Health Services, etc.);

2. coverage starts first of month following 30 calendar days of employment.

3. your enrollment is due to a special event defined under the Special Enrollments Provision; or

4. a divorce decree states that the ex-spouse is to provide a particular coverage for your dependent child.

Supportive documentation in the form of a letter from the other plan or employer verifying other coverage is required when #1 applies. (A current insurance identification card is an acceptable form of supportive documentation if it lists the dependent's name and the type of his or her coverage.)

Supportive documentation as determined by CNM is required when #2 or #3 apply (i.e., evidence of involuntary loss of coverage that specifies who lost what coverage, on what date and why the coverage was lost; original official state publicly filed birth certificate or marriage certificate; divorce decree; etc.).

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CHANGE OF STATUS

If you (*or in some cases, your dependents*) have a change of status due to the following qualifying events, you must report this change in status by completing, signing, and turning a change card to CNM's benefits office within 30 days from the qualifying event (*or when you and CNM enter your enrollment on the CNM online benefit system at* www.phs.org/cnm):

QUALIFYING EVENTS:

- Birth
- Marriage
- Adoption of a child or child placement order in anticipation of adoption
- Incapacity of a child covered under the CNM Group Plan
- Legal guardianship of a child
- Promotion to a new job classification with a salary increase, or employment status change from a part-time position to a full-time position with a salary increase (*provided you are fulfilling the actively-at-work requirement*)
- Divorce or Annulment (*not a legal separation*)
  - You cannot cancel a spouse when a divorce is in progress.
  - You are required to cancel an ex-spouse effective on the last day of the month your divorce becomes final (you will be required to provide certain pages of your final divorce decree or proof the divorce became final).
  - If you lose other health insurance coverage as a result of divorce, you may apply to enroll in the coverage(s) lost by providing the appropriate supportive documentation listed under the next bullet point.
- Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage (This may include an involuntary loss of medical insurance, dental insurance, vision insurance, exhaustion of COBRA, etc. IMPORTANT: You will be required to provide CNM's benefits office with a loss of coverage letter specifying who lost coverage, what type of coverage was lost, what day coverage was lost, and why coverage was lost. If the letter does not address each of these factors, we cannot determine the loss of coverage to be an involuntary loss of coverage and your enrollment may not be accepted.)
- Loss of employment (including retirement)
- Establishment of termination through affidavit terminating domestic partnership
- Establishment of an affidavit of domestic partnership
- Death

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependent in the Plan.

You must request enrollment within 30 days after your other coverage involuntarily ends. Exception: You have 60 days from the date of involuntary loss of Medicaid coverage or the children's Health Insurance Program (CHIP) to apply.

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SPECIAL ENROLLMENT EVENTS FOR MEDICAL COVERAGE ONLY:

Special enrollment events mandated by state and federal laws permit you to apply to enroll in medical coverage within 30 days from the occurrence of a special event.

If you meet eligibility requirements for medical coverage and **are not enrolled in the CNM Medical Plan**, you may enroll yourself only, or yourself and one or more eligible dependents for CNM medical coverage within 30 days from the occurrence of the following special events:

- You suffer an involuntary loss of coverage because coverage of your spouse (*or domestic partner, if applicable*) or child under another plan is terminated as a result of divorce, death, termination of employment, reduction in hours, legal separation, or termination of employer contributions
  You get married or you establish domestic partnership by affidavit. A child is born to you or your spouse
- You adopt a child or a child is placed for adoption in your family
- You or any eligible dependent suffer an involuntary loss of Medicaid or CHIP coverage (*you have 60 days from date of this type of loss to apply; and proof is required*)

To report your change of status due to a qualifying event or a special enrollment event, you are required to complete, sign and turn in a change card and supportive documentation, or you and CNM may enter your change and upload the supportive documentation on the CNM online enrollment system at www.phs.org/cnm within 30 days from the date of your qualifying or special event. If you do not meet this 30-day deadline, you may apply for coverage during the established open enrollment in the fall with an effective date of January 1.

Further, if you do not report a change of status that causes your spouse or child to become ineligible either within 60 days from the qualifying event or within 60 days from the day coverage would end; your spouse or child will not be eligible for COBRA continuation coverage under the CNM Group Plan. When a spouse or child becomes ineligible, coverage under CNM Group Plan ends for him/her on the last day of the month for which he/she becomes ineligible. (Even though you have 60 days to report this change as it pertains to COBRA continuation coverage, CNM Rules require that you report this change of status within 30-days from the qualifying event in order to avoid overpayment of premium. This alerts CNM to notify the carriers about your spouse's ineligibility to avoid unnecessary claim payments. This also allows CNM to make the necessary premium adjustments, if any, to your payroll check.)

CNM will retract or collect claim overpayments from you (the employee) when you are late in reporting an ineligible spouse or ineligible dependent.

> **Example #1**: You divorce (or terminate your domestic partnership) on July 12; this causes your ex-spouse (or ex-domestic partner) to become ineligible effective July 31. You should immediately visit your employee benefits office to drop your ex-spouse (or ex-domestic partner) and any enrolled stepchildren (or your domestic partner's children), if applicable, from the CNM Group Plan. Provide your employee

benefits office with a copy of your divorce decree (or termination of domestic partner affidavit) and a "signed" record change card. Your ex-spouse (or ex-domestic partner) may apply for COBRA continuation coverage provided that you report this change of status within the timeframe listed above.
(**REMINDER**: *Review your beneficiary designation and make any changes you wish. Life insurance proceeds may not be payable to an ex-spouse unless the ex-spouse is re-designated as beneficiary after the divorce becomes final.)*

When you are electing CNM Group coverage, you will be required to complete, sign, and turn in the appropriate application, or you and CNM may enter your enrollment and upload the supportive documentation on the CNM online benefit system at www.phs.org. In the event of a dependent enrollment, CNM's benefits office is required to view the supportive documentation you have presented. Without the appropriate supportive documentation, your dependent's effective date of coverage will be delayed, if supportive documentation is not provided by the established deadline (*30 days from your effective date or 30 days from the qualifying event), your dependent will not be eligible for coverage until January 1)*.

ADDRESS AND PHONE NUMBER CHANGES

In order for each insurance carrier affiliated with your CNM coverage to process your address and/or phone number changes, you must report address and phone number changes directly to CNM's benefits office on the appropriate form, or you may enter these changes online at www.phs.org

TERMINATION OF COVERAGE EFFECTIVE DATES

Coverage terminates for CNM Group participation as follows:

- ***Employees*** – Coverage terminates at the end of the period for which deductions are made from your payroll check. This termination date is determined by your employer.
- ***Actively Serving Board Members*** – Coverage terminates on the last day of the month in which the board member's term expires.
- ***Dependents (spouse/domestic partner and dependent child)*** – Coverage terminates on the last day of the month in which the eligible dependent becomes ineligible (i.e., coverage for an ex-spouse and stepchildren or the ex-domestic partner's children terminates on the last day of the month in which the divorce becomes final or domestic partnership terminates; coverage for any other dependent child ends on the last day of the month in which the child reaches the limiting age of 26).
- ***Employees on an extended leave of absence (LOA)*** –CNM determines when your coverage ends under the active plan. CNM's policy may allow you to remain on the active plan for up to one year from the date your LOA was approved, so be sure to contact CNM's benefit office one month prior to reaching this 12-month period to discuss your coverage options. **ALSO**, be sure to contact CNM's benefits office **WITHIN 30 DAYS** from **returning from your LOA** to discuss your benefits or premiums that may have been suspended while you were on LOA. (*Further, if you are on LOA*

due to disability, be sure to review information regarding benefits you may be eligible for under your life or disability coverage provided by The Standard.)

- ***Open Enrollment*** – CNM offers open enrollment each fall for medical, dental, and vision coverage. Once you apply (prior to January 1), the change becomes effective on January 1.
- ***The No CNM Double Coverage Rule*** – If both of you and your spouse work for a CNM employer, you and your spouse may not enroll each other as a spouse, nor may you both cover your children. If your child is also an employee of a CNM participating entity and enrolled for employee coverage, you may not cover your child as a dependent for the lines of coverage your child is enrolled as an employee. Double coverage outside of the CNM Group Plan is allowed.

COVERED SERVICES

Benefits are subject to the Copayments, Deductibles, and Coinsurance listed in the *Summary of Benefits*. Please refer to Section 4– Limitations and Exclusions, for details regarding the Limitations and Exclusions applicable to this Plan. **Any services received must be Medically Necessary to be covered.**

NOTE:
If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in Section 5- Filing Claims.

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

MEDICAL EMERGENCY CARE

Treatment for a Medical Emergency or Accidental Injury in the Emergency Room of a Hospital or an Urgent Care facility is a benefit. No notification to Presbyterian Health Plan is required. Please refer to the *Summary of Benefits* for Emergency Room Visit or Urgent Care Center Copayments and/or Coinsurance. Treatment in a Physician's office or an Ambulatory Surgical Facility is also a benefit and is paid as any other illness.

Definition of Emergency: Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health, if pregnant the health of you or your unborn child; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. Initial treatment must be sought within 48 hours or as soon as reasonably possible of the accident or onset of symptoms to qualify as emergency care. Acute medical emergency care is available 24 hours per day, 7 days a week.

Examples of a Medical Emergency include but are not limited to a heart attack, poisoning, severe allergic reaction, convulsions, unconsciousness, and uncontrolled bleeding.

The Plan will provide reimbursement when a Member, acting in good faith, obtains emergency Medical Care for what reasonably appears to the Member, acting as a reasonable layperson, to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent.

If your emergency treatment requires direct Admission to the Hospital, you are responsible for the Hospital Copayment, but you do not have to pay a separate Copayment/Coinsurance for the emergency room visit.

No notification or **Prior Authorization** is required for Out-of-network (including out of state) Hospitals or treatment facilities for Medical Emergency services.

Member may be responsible for the Copay and/or Deductible and Coinsurance as outlined on the *Summary of Benefits*

Coverage for trauma services and all other emergency services will continue at least until the Member is medically stable, does not require critical care, and can be safely transferred to another facility based on

the judgment of the Attending Physician in consultation with Presbyterian Health Plan. Presbyterian Health Plan may require that the Member be transferred to a Hospital participating in its Provider network, if the patient is stabilized and the transfer completed in accordance with federal law.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

URGENT CARE

The Plan will reimburse for all services rendered in an Urgent Care facility or setting, unless otherwise limited or excluded, if provided by a licensed Provider and/or an appropriate facility for treating urgent medical conditions. Members may contact our Customer Service Center for information regarding the closest In-network facility that can provide Urgent Care.

For Urgent Care, no notification is required. For care obtained from Out-of-network Urgent Care Providers, the Member will be responsible for the Deductible and Coinsurance as outlined on the *Summary of Benefits*, as well as those charges above Medicare allowable.

ACUPUNCTURE SERVICES

Acupuncture treatment is a benefit only if performed by a licensed Physician, Osteopath, or Doctor of Oriental Medicine acting within the scope of his/her license.

Benefits for Acupuncture, including office calls, treatment, and Acupuncture are limited as specified in the *Summary of Benefits*, in combination with chiropractic, massage therapy services, and Rolfing services. In addition, for ancillary treatment modalities associated with Acupuncture Services, other Plan limitations may apply.

AMBULANCE SERVICES

Benefits are available for professional Ambulance Services if they are Medically Necessary to protect the life of the Member, and transportation is to the closest Hospital that can provide Covered Services appropriate to the Member's condition.

Ambulance Service means local transportation in a specially designed and equipped vehicle used only for transporting the sick and injured. Air ambulance is a benefit when Medically Necessary, such as for a high-risk Maternity or newborn transports to a tertiary care facility.

A *tertiary care facility* is a Hospital unit that provides:

- Complete perinatal care occurring in the period shortly before and after birth;
- Intensive care of intrapartum patients occurring during labor or delivery;
- Prenatal high-risk patients; and
- The coordination of transportation, communication, and data analysis systems for the geographic area served.

The ambulance Copayment or Deductible and Coinsurance is waived if transportation results in an Inpatient Hospital Admission.

There are no benefits when the ambulance transportation is primarily for the convenience of the Member, the Member's family, or the healthcare Provider.

Autism Spectrum Disorder

The diagnosis and treatment for Autism Spectrum Disorder is covered for children, from birth to age nineteen (19) (or up to age twenty-two (22) if enrolled in high school) in accordance with the state mandate as follows:

1. Diagnosis for the presence of Autism Spectrum Disorder when performed during a well-child or well-baby screening; and/or
2. Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with the state mandate.

Autism Spectrum Disorder Services must be provided by participating Providers/Practitioners who are certified, registered or licensed to provide these services. Applied Behavior Analysis (ABA) and other Autism Spectrum Disorder services may require Prior Authorization prior to being provided. If Prior Authorization is not obtained when required, the claim may be denied.

Limitation- Service received under the federal individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three (3) to twenty-two (22) years of age who have Autism Spectrum Disorder are not covered under this plan.

BEHAVIORAL HEALTH AND ALCOHOLISM AND/OR SUBSTANCE ABUSE

To obtain benefits for Outpatient Services related to Behavioral Health and Alcoholism and/or Substance Abuse, it is not necessary to obtain **Prior Authorization**. However, you can call the Presbyterian Health Plan Behavioral Health Department directly at (505) 923-5470 or toll-free 1-800-453-4347, if you have any questions.

The following benefits and limitations are applicable for Behavioral Health and Alcoholism or Substance Abuse Services. In all cases, Behavioral Health treatment and Alcoholism and/or Substance Abuse treatment must be Medically Necessary in order to be covered. **Day/visit limitations** listed in the *Summary of Benefits* apply to the Alcoholism and/or Substance Abuse only.

Outpatient services are available from the following credentialed Providers:

- Medical Doctors, Board Eligible or Board Certified in Psychiatry (M.D.);
- Licensed Psychologists (L.P.);
- Licensed Independent Social Workers (L.I.S.W.);
- Licensed Clinical Mental Health Counselors (L.P.C.C.);
- Licensed Marriage and Family Therapists (L.M.F.T.);
- Clinical Nurse Specialists (C.N.S.); and
- Licensed Alcohol and Drug Abuse Counselors (L.A.D.A.C.) with Master's degree in counseling or social work.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

BEHAVIORAL HEALTH SERVICES

Inpatient Behavioral Health Services will be covered when performed by a licensed Provider. **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department is required prior to services being provided. Please call (505) 923-5470 or toll-free at 1-800-453-4347.

If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior Authorization** when required, benefits will be administered at the Out-of-network level and Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*.

Partial hospitalization can be substituted for the Inpatient Behavioral Health Services Partial hospitalization is a non-residential Hospital-based day program attended by the Member at least 3 hours a day but not more than 12 hours in any 24-hour period which includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Inpatient Behavioral Health Services require **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

Outpatient, non-Hospital based short-term evaluative and therapeutic Behavioral Health Services will be provided based on medical necessity.

Coverage includes services for diagnostic tests, anesthetics, x-ray and laboratory examinations, and other care provided by a professional Provider, Hospital or Alcoholism treatment center.

Outpatient services also consist of treatment including individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Abuse for most Behavioral Health diagnoses. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a mental disorder or medical condition are also a covered benefit.

ALCOHOL AND/OR SUBSTANCE ABUSE SERVICES

Benefits for Alcoholism and or Substance Abuse are limited to the number of days listed in the *Summary of Benefits*. Inpatient services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being reduced or denied.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level and the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*.

Inpatient treatment in a Hospital or Substance Abuse treatment center requires **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. Coverage will be provided up to the number of days listed in the *Summary of Benefits* per Member per Calendar Year. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*.

Partial hospitalization can be substituted for Inpatient Alcoholism and/or Substance Abuse services. Partial hospitalization is a non-residential day program, attended by the Member at least 3 hours a day but not more than 12 hours in any 24-hour period, based in a Hospital or treatment center that includes various daily and weekly therapies. Two partial hospitalization days are equivalent to one day of Inpatient care. Partial hospitalization services require **Prior Authorization** by Presbyterian Health Plan's Behavioral Health Department. Failure to obtain **Prior Authorization** for services may result in a reduction in benefits (as listed on the *Summary of Benefits*) or a denial of benefit. Please refer to the *Summary of Benefits* for day limitations.

Outpatient, non-Hospital based intensive and standard Outpatient evaluative and therapeutic services for Alcoholism and/or Substance Abuse will be covered.

The combined coverage for all Outpatient evaluative and therapeutic Alcohol and/or Substance Abuse services (both intensive and standard) is **limited** to the number of visits per Member per Calendar Year listed in the *Summary of Benefits*. Intensive Outpatient Alcohol and/or Substance Abuse services are defined as visits lasting up to 9 hours per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes**.**

Coverage includes services for diagnostic tests, anesthetics, x-ray and laboratory examinations, and other care provided by a professional Provider, Hospital or Alcoholism treatment center.

Treatment in Residential Treatment Centers requires **Prior Authorization** from Presbyterian Health Plan. Failure to obtain **Prior Authorization** prior to services being rendered will result in a denial of coverage. Benefits are available only to members aged 18 and older and are limited as specified on the *Summary of Benefits*.

Outpatient services also consist of treatment including individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Abuse for most Behavioral Health diagnosis. In addition, therapies for marriage, family and relationship problems, physical and/or sexual abuse, and problems related to a mental disorder or medical condition are also covered.

BIOFEEDBACK

Biofeedback is a benefit when prescribed for the following physical conditions only: chronic pain treatment, Raynaud's disease/phenomenon, tension headaches, migraines, urinary incontinence and craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders. Biofeedback is a benefit only when provided by a Medical Doctor, a Doctor of Osteopathy, or a professional Psychologist.

Benefits for covered Biofeedback Services, including office calls, are limited to the conditions listed above.

CLINICAL TRIALS

If you are a qualified individual participating in an approved Clinical Trial, you may receive coverage for certain routine patient care costs incurred in the trial.

A **qualified individual** is someone who is eligible to participate in an approved Clinical Trial according to the trial protocol with respect the treatment of cancer or another life-threatening disease or condition; and either (1) the referring health care professional is a participating provider and has concluded that participation in the clinical trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation would be appropriate.

An **approved Clinical Trial** is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition and is:

1. Conducted under an investigational new drug application reviewed by the Food and Drug Administration;
2. A drug trial that is exempt from having such an investigational new drug application; OR
3. Is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    a. The National Institutes of Health;
    b. The Centers for Disease Control and Prevention;
    c. The Agency for Health Care Research and Quality;
    d. The Centers for Medicare & Medicaid Services;
    e. A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; OR
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the Secretary of Health and Human Services determines that the study has been reviewed and approved through a system of peer review that (i) is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the heist scientific standards by qualified individuals who have no interest in the outcome of the review.

Routine patient care costs that are covered are items or services that would be covered for a member or beneficiary who is not enrolled in a clinical trial. All applicable plan limitations for coverage of out-of-network care will still apply to routine patient costs in clinical trials.

Routine patient care costs **do not** include:

- The actual clinical trial or the investigational service itself;
- Cost of data collection and record keeping that would not be required but for the clinical trial; Items and services provided by the clinical trial sponsor without charge;
- Travel, lodging, and per diem expenses;
- A service that is clearly inconsistent with widely accepted and established standards for a particular diagnosis; and

- Any other services provided to clinical trial participants that are necessary only to satisfy the data collections needs of the clinical trial.

If the benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

CARDIAC/PULMONARY REHABILITATION

Benefits are available for Outpatient cardiac and/or pulmonary rehabilitation programs. See *Summary of Benefits* for appropriate Copayments, Deductible, and/or Coinsurance.

CHEMOTHERAPY/DIALYSIS/RADIATION THERAPY

Benefits are available for the following Inpatient or Outpatient therapeutic services:

- Treatment of malignant disease by standard chemotherapy;
- Treatment for removal of waste materials from the body; including renal dialysis, hemodialysis, or peritoneal dialysis, the cost of equipment rentals and supplies; and
- Treatment of disease by x-ray, radium, or radioactive isotopes.

CHIROPRACTIC SERVICES

Services administered by a Chiropractor on an Outpatient basis are a benefit if necessary for treatment of an illness or Accidental Injury. ***No*** chiropractic benefits are paid for Maintenance Therapy as determined by Presbyterian Health Plan.

Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits*, in combination with benefits for Acupuncture, massage therapy and Rolfing services. In addition, for ancillary treatment modalities associated with chiropractic services, other Plan limitations may apply.

DENTAL CARE AND MEDICAL CONDITIONS OF THE MOUTH AND JAW

DENTAL ACCIDENTS

Treatment for conditions that are the direct result of Accidental Injury to the jaw, sound natural teeth, mouth or face is a benefit. Injury because of chewing, biting, or malocclusion is **not** considered an Accidental Injury.

Sound natural teeth are teeth that are whole or properly restored by amalgams, without impairment, periodontal or other conditions, and not in need of treatment for any reason other than the Accidental Injury. Teeth with crowns or restorations (including dental implants) are not considered sound natural teeth.

To be covered, *initial* treatment for the injury must be sought within 72 hours of the accident. All covered treatments for dental trauma must be completed within one year of the specific traumatic injury.
If craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are a result of trauma such as a bodily injury or blow caused solely through external, violent, and unforeseen means, benefits are available for diagnostic examination, x-rays, medications, physical therapy, dental splints, Acupuncture, orthodontic appliances and treatment, crowns, bridges, and dentures. Trauma does not include injury because of biting, chewing, or malocclusion.

When alternative dental or surgical procedures or Prosthetic Devices are available, the dental accident benefit allowance is based upon the least costly procedure or Prosthetic Device.

HOSPITALIZATION FOR DENTAL CARE

Benefits are paid for an Ambulatory Surgery Facility or Hospital Outpatient service for dental procedures ***only*** if the patient has a non-dental, physical condition that makes hospitalization Medically Necessary. The Dentist's services for the procedure may not be covered, if determined to be primarily dental in nature and unrelated to the treatment of dental trauma. Pediatric anesthesia in a day surgical unit may be a covered benefit for pediatric dental procedures if found to be Medically Necessary.

If a Member is admitted for care, **Prior Authorization** is required. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*. In-network Providers will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorization** with your Physician. The dental procedure itself is not a covered benefit unless conditions for trauma or oral Surgery are met.

ORAL SURGERY AND TMJ TREATMENT

Oral dental Surgery benefits are available for cutting procedures for diseases, such as, but not limited to:

- The removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required;
- The removal of teeth required due to a side effect from radiation or chemotherapy treatment, before radiation therapy of a cancerous area, or Medically Necessary due to damage from medical treatment (such as prolonged, Medically Necessary use of certain oral medications);
- The external or intraoral cutting and draining of cellulitis (inflammation) that extends beyond the dental space;
- The surgical correction of prognathism with handicapping malocclusion, a marked projection of the lower jaw that interferes with chewing;
- The removal of bony growths on the jaws and hard palate, unless done in preparation of the mouth for dentures;
- The incision of accessory sinuses, salivary glands, or ducts;
- The reduction of dislocations such as TMJ Surgery; and
- Lingual frenectomy.

Oral dental Surgery benefits require **Prior Authorization** only if admitted. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization,** when required. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician. Oral Surgery procedures that are covered by your dental carrier's coverage are provided *only* if a covered benefit under this Plan. Benefits are payable based upon the Coordination of Benefits (COB) requirements set forth in Section 5– Filing Claims, of this booklet.

Benefits are also available for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders to include surgical and non-surgical treatment including diagnostic examination, x-rays, medications, physical therapy, dental splints, and Acupuncture. Benefits do **not** include orthodontic appliances and treatment, crowns, bridges, or dentures unless the disorder is trauma related. (For treatment due to an Accidental Injury, see "Dental Accidents" in this Section.)

Nonstandard diagnostic, therapeutic, and surgical treatments of Temporomandibular Joint Disorder (TMJ) are ***not*** benefits under any circumstances. Periodontal Surgery and removal of impacted wisdom teeth are also **not** Covered Services.

DIABETES EDUCATION

Diabetes Education is a covered benefit and includes coverage for any Provider rendering education or instructional services for diabetes. When services are obtained from In-network Providers, the Copayment applies to the professional Provider's services **only.** When services are obtained from Out-of-network Providers, the applicable Coinsurance applies to all services billed.

- **Insulin Pump Training** - one initial session and one follow-up session.
- **Type I Diabetes.** For Members 18 years of age and under, up to six visits to normalize glucose within two months of diagnosis; thereafter, up to one visit per month as needed to maintain control of diabetes. For Members over 18 years of age, up to six visits to normalize glucose within two months of diagnosis; then up to one visit per month for the first year following diagnosis; thereafter, up to four visits per year.
- **Type II Diabetes.** Up to four visits for initial education, plus if insulin is initiated, up to three visits for insulin start up and management; thereafter, up to four follow up visits per Calendar Year.
- **Diabetes Occurring Only During Pregnancy ("Gestational Diabetes").** One initial visit; thereafter two follow up visits per month. In addition, one visit within six months following delivery for conception counseling for patients planning additional children.
- **Hypoglycemia and Glucose Intolerance.** Up to three visits to provide necessary nutritional counseling to delay or prevent onset of diabetes.
- **Additional visits** - include following a Physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; or visits when re-education or refresher training is prescribed by a healthcare Provider with prescribing authority.

DIABETES SUPPLIES AND SERVICES

The following Diabetes Supplies and equipment are covered for diabetic Members and Members with elevated blood glucose levels due to pregnancy:

- Insulin pump supplies (not to exceed a 30-day supply purchased during any 30-day period).
- Injection aids, including those adaptable to meet the needs of the legally blind
- Insulin pumps
- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, when **Prior Authorization** is obtained from Presbyterian Health Plan, custom molded inserts, replacement inserts, preventive devices, and shoe modifications
- Blood glucose monitors, including those for the legally blind.

Prior Authorization Prior Authorization is a clinical evaluation process to determine if the requested Health Care Service is Medically Necessary, a Covered Benefit, and if it is being delivered in the most appropriate health care setting. Our Medical Director or other clinical professional will review the requested Health Care Service and, if it meets our requirements for Coverage and Medical Necessity, it is Authorized (approved) before those services are provided.

The Prior Authorization process and requirements are regularly reviewed and updated based on various factors including evidence-based practice guidelines, medical trends, Practitioner/Provider participation, state and federal regulations, and our policies and procedures.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

DIAGNOSTIC SERVICES

Diagnostic Services including laboratory tests and x-rays to detect a known or suspected illness or Accidental Injury are covered if ordered by a Provider, including:

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- Prenatal genetic testing unless it is determined to be Investigational;
- Chromosome analysis, including karyotyping and molecular cytogenetic testing;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Hearing tests **only** for the treatment of an illness or Accidental Injury (except as outlined below under "Hearing Aids");
- Magnetic Resonance Imaging (MRI);
- Positron Emissions Tomography (PET) scans (require **Prior Authorization**);
- Home/Sleep disorders;
- Allergy testing; and
- CT scans.

Unless otherwise noted, **Prior Authorization** is not required for the Diagnostic Services listed above.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

DURABLE MEDICAL EQUIPMENT AND APPLIANCES, HEARING AIDS, MEDICAL SUPPLIES, ORTHOTICS, AND PROSTHETICS

Benefits are available for the following items and supplies, when determined to be Medically Necessary:

- The rental or, at the option of Presbyterian Health Plan, the purchase of Durable Medical Equipment when prescribed by a Physician or other professional Provider and required for therapeutic use, including Wheelchairs, Hospital beds, crutches, and other necessary Durable Medical Equipment;
- Purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity;
- Prosthetic eyes and prosthodontic appliances;
- Breast Prosthetics when required as the result of a mastectomy;
- Orthotic (a rigid or semi-rigid supportive device) or Orthopedic Appliance (Prefabricated) that supports or eliminates motion of a weak or diseased body part. This does not include foot orthotics, functional or otherwise except for Members with diabetes or other significant neuropathies when Prior Authorization is obtained from Presbyterian Health Plan;

- Custom-Fabricated knee-ankle-foot orthoses (AFO and/or KAFO) for Members up to eight years old;
- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury and prescribed by a Physician. (Duplicates are **not covered,** and replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.);
- Hearing aids
  - Hearing aids and the evaluation for fitting of hearing aids are covered for children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months "per hearing impaired" ear, thereafter member pays 90% Coinsurance. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit.
  - All other members – hearing aid benefits are limited to a maximum of $500 in benefit payments during any 36-month period, thereafter member pays 90% Coinsurance. This benefit does not include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. The 36-month period is not based on a Calendar Year. The 36-month period begins on the date you purchase your first hearing aid and ends 36 months later. This benefit does include repair and replacement of hearing aids;
- Stethoscopes and manual blood pressure cuffs that are prescribed by a Physician. Automatic blood pressure cuffs or monitors are **not covered** unless the Member is physically unable to use a manual cuff; and
- Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member's condition, or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Surgically implantable devices and prostheses are covered as follows:

- Surgically implanted Prosthetics or devices, including penile implants required as a result of illness or injury;
- Implantable mechanical devices such as cardiac pacemakers or defibrillators, insulin pumps, epidural pain pumps, and neurostimulators;
- Intra-ocular lenses;
- Cochlear implants (see "Surgery" for additional information about benefits available for cochlear implantation);
- Teflon/dacron surgical grafts and meshes; and
- Artificial or porcine heart valves.

When alternative Prosthetic/Orthotic Devices are available, the allowance for a Prothesis/Orthosis will be based upon the least costly item.

Medical Supplies
The following medical supplies are covered, not to exceed a one-month supply purchased during any 30-day period:

- Colostomy bags, catheters;
- Gastrostomy tubes;
- Hollister supplies;
- Tracheostomy kits, masks;
- Lamb's wool or sheepskin pads;
- Ace bandages, elastic supports;
- Mastectomy brassieres when required due to a mastectomy (Benefits are limited to six bras per Calendar Year.);
- Support hose when prescribed by a Physician for the Medically Necessary treatment of varicose veins (Benefits are limited to 12 pairs or 24 hose per Calendar Year.); and
- Other supplies determined by Presbyterian Health Plan to be Medically Necessary and covered under the Plan.

Prior Authorization from Presbyterian Health Plan is required for:

- Durable Medical Equipment, medical supplies (including enteral feeding tubes), orthopedics appliances, orthotics, and surgically implanted Prosthetics; and

In-network Providers will request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied.

For Durable Medical Equipment and supplies under the amount shown in the *Summary of Benefits*, **Prior Authorization** is not required. However, Medical Necessity must exist.
Benefits are **not** available for the following items:

- Deluxe equipment such as motor-driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate;
- Rental of Durable Medical Equipment if the patient is in a facility that provides such equipment;
- Cost of repairs that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;
- Dental appliances including dentures;
- Equipment that is primarily non-medical such as heating pads, hot water bottles, water beds, Jacuzzi units, specialized clothing, hot tubs, or exercise equipment;
- Environmental control equipment such as air conditioners, dehumidifiers, or electronic air filters, regardless of the therapeutic value they may provide;
- Accommodative foot orthotics, which are used to accommodate the structural abnormalities of the foot by providing comfort, but not altering function;
- Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by Presbyterian Health Plan), except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan;
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints, except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan;
- Custom-Fabricated Orthotics/Orthosis except for knee-ankle-foot Orthosis (AFO and/or KAFO) devices for Members up to eight years old; and

- Duplicate equipment is **not covered** under this Plan.

FAMILY PLANNING AND RELATED SERVICES

Family planning services are covered for the following procedures (all contraceptives are covered In-network):

- Injection of Depo-Provera for birth control purposes;
- Diaphragm, including fitting;
- Birth control devices, including surgical implantation and removal;
- IUDs or cervical caps, including fitting, insertion, and removal;
- Prenatal genetic counseling;
- Surgical sterilization procedures such as vasectomies and tubal ligations (If the tubal ligation is done during a delivery, only the Maternity Copayment applies. There will not be an additional Surgery Copayment.); and
- RU486 administered by a Physician.

Only the following infertility-related treatment and testing services are covered (note that the following procedures only secondarily also treat infertility):

- Surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is not the result of a surgical sterilization; and
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone being replaced.

The above services are **the only infertility-related treatments** that will be considered for benefit payment. Infertility testing is covered only to diagnose the cause of infertility. **Once the cause has been established and the treatment determined to be non-covered, no further testing is covered.** This Plan will also cover testing related to one of the covered treatments, listed above (such as lab tests to monitor hormone levels). However, daily ultrasounds to monitor ova maturation are **not covered** since the testing is being used to monitor a non-covered infertility treatment.

This Plan **does not cover** any services or charges for artificial conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, GIFT, ZIFT, all drugs, hormonal manipulation, or embryo transfer is not a covered benefit. **Any artificial conception method not specifically listed is also excluded.**

GENETIC INBORN ERRORS OF METABOLISM DISORDERS (IEM)

Coverage is provided for diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the limitations and exclusions (Section 4), and **Prior Authorization** (Section 1) requirements listed in the Member Benefit Booklet. Medical services provided by licensed healthcare professionals, including physicians, dieticians and nutritionists, with specific training in managing Members diagnosed with Genetic Inborn Errors of Metabolism (IEM) are Covered. Covered Services include:

- nutritional and medical assessment;
- clinical services;
- biochemical analysis;
- medical supplies;
- Prescription Drugs;
- corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM); and

- nutritional management.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

HOME HEALTH CARE

If a Member needs health care at home, benefits are available for services provided by a Home Health Agency. This benefit provides Skilled Nursing services when ordered by a Physician and administered in the home on an intermittent basis. A visit is one period of home health service of up to four hours.

Before the Member receives home health care, the treating Physician or Home Health Agency must request **Prior Authorization** from Presbyterian Health Plan. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician before obtaining services. The following home Healthcare Services **are covered:**

- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Physical, occupational, or respiratory/inhalation therapy, by licensed or certified therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist;
- Skilled services by a qualified aide to do such things as change dressings, check blood pressure, pulse, and temperature;
- Medical supplies, drugs, and laboratory services that would have been provided by a Hospital had the Member been hospitalized;
- Physician home visits;
- Home Intravenous services; and
- Enteral feeding equipment and food.

There are **no** home healthcare benefits provided for care that:

- Is provided primarily for the convenience of the Member or the Member's family;
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter; or
- Is provided by a nurse who ordinarily resides in the Member's home or is a Member of the patient's immediate family.

HOSPICE CARE

Hospice benefits are available for Covered Services provided by an approved Hospice agency, or Hospital or other facility by or on behalf of a Hospice agency and received during a Hospice benefit period.

Before the Member receives Hospice care, the treating Physician or Hospice agency must request **Prior Authorization in writing** from Presbyterian Health Plan. **Prior Authorization** requires a written treatment program approved by the treating Physician. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for a **Prior Authorization** with your Physician before obtaining services.

The Hospice benefit period must begin while the patient is covered for these benefits, and coverage must be continued throughout the benefit period. The benefit period is defined as beginning on the date the treating Physician certified that the patient is Terminally Ill with a life expectancy of six months or less, ending six months after it began or upon the death of the patient, if sooner.

If the patient requires an extension of the benefit period, the Hospice agency must provide a new treatment plan and the treating Physician must re-certify the patient's condition to Presbyterian Health Plan. No more than one additional Hospice benefit will be approved.

Benefits are available ***only*** for, or on behalf of, an approved Hospice agency. An approved Hospice agency must be:

- Licensed when required;
- Medicare-certified as a Hospice agency; or
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Hospice agency.

The following services ***are covered*** under this Hospice benefit:

- Inpatient Hospice care;
- Hospice care Physician benefits;
- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Home health care by a home health aide;
- Physical therapy, speech therapy, or occupational therapy;
- Medical supplies; and
- Drugs and medications for the Terminally Ill Patient.

In addition to the Hospice services listed above, you have coverage for:

- Services of a medical social worker (MA or MSW) for patient or family counseling, to include bereavement counseling limited to 3 visits; and
- Respite care for a period not to exceed ten continuous days. No more than two respite care stays are available during a six-month Hospice benefit period. *Respite care* provides a brief break from total care given by the family.

Hospice benefits are **not** available for the following services:

- Food, housing, or delivered meals;
- Medical transportation;
- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing; and
- Pastoral and spiritual counseling.

The following services are **not** benefits under Hospice but may be covered elsewhere under this booklet, subject to applicable Copayment, and Coinsurance provisions:

- Acute Inpatient Hospital care for curative services;
- Durable Medical Equipment;
- Non-Hospice care Physician visits; and
- Ambulance Services.

HOSPITAL INPATIENT SERVICES

When a Member receives acute Inpatient medical/surgical or pregnancy related Hospital care, benefits are available for covered room and board and other covered Hospital services.

Benefits are available for a non-private room with two or more beds. Private room charges are a covered benefit only when Medically Necessary and when the private room is ordered by the admitting Physician and **Prior Authorization** is obtained from Presbyterian Health Plan. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. If the Member requests a private room or the private room is not Medically Necessary, Presbyterian Health Plan bases payment on the Hospital's average non-private room rate and the Member is responsible for the balance. The balance you pay does not apply to the Out-of-pocket Maximum.

Benefits are available for other room accommodations or Special Care Units such as:

- Intensive Care Unit (ICU);
- Cardiac Care Unit (CCU);
- Sub-Intensive Care Unit; and
- Isolation Room.

If you are re-admitted to a facility (or transferred to a Rehabilitation Hospital or Skilled Nursing Facility) within 15 days of discharge from an Inpatient facility that was treating you for the same condition, the Copayment for the re-Admission (or transfer) is waived.

BLOOD

Benefits are available for blood transfusions, blood plasma, blood plasma expanders, and the charges for directed donor or autologous blood storage fees **if** the blood is to be used during a procedure that has been scheduled for that Member.

PHYSICAL REHABILITATION – INPATIENT

Benefits are available for Inpatient rehabilitation services that are Medically Necessary to restore and improve lost functions following illness or Accidental Injury. Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Member is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and **not** for personal convenience.

There are **no** benefits for Maintenance Therapy or care provided after the patient has reached his/her rehabilitative potential. In the case of a dispute about whether the patient's rehabilitative potential has been reached, the patient is responsible for furnishing documentation from the treating Physician supporting that the patient's rehabilitative potential has not been reached.

MASSAGE THERAPY

Only services administered by a licensed Physical Therapist, Licensed Massage Therapist, a Medical Doctor, a Doctor of Osteopathy, a Doctor of Oriental Medicine, or a Chiropractor operating under the scope of their license on an Outpatient basis are a covered benefit if necessary for treatment of an illness or Accidental Injury. ***No*** benefits are paid for Maintenance Therapy. Benefits are subject to a Calendar Year limit as shown in the *Summary of Benefits* in combination with benefits for Acupuncture and chiropractic services.

MATERNITY AND NEWBORN CARE

Benefits include complete prenatal care, pregnancy related diagnostic tests, Prescription Drugs, visits to an obstetrician, Certified Nurse-Midwife, or Licensed Midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse-Midwife or Physician. Benefits are available for delivery at home by a Certified Nurse-Midwife or a Licensed Midwife. Lay midwife deliveries are not a covered benefit. Deliveries by cesarean section, ectopic pregnancies, other pregnancy complications, such as miscarriage, and therapeutic or elective abortions are also covered.

If Maternity benefits change during a pregnancy, the Member receives the benefits in effect on the day the service is received. Under Two-Party or Family Coverage, a Dependent daughter is eligible for Maternity benefits. Coverage for the newborn is available ***only*** if covered as an eligible Dependent.

Note:

Coverage for your newborn begins on your newborn's date of birth, provided that you are enrolled in CNM Family Medical Coverage. (Please contact CNM's benefits office to finalize this enrollment. To avoid delay in claims payments, please finalize this enrollment within 30 days from your newborn's date of birth). **If you are not enrolled in CNM Family Medical Coverage, your newborn will not be automatically covered from date of birth. In such case, you are required to enroll your newborn within 30 days from your newborn's date of birth. (If you miss this 31-day enrollment period, your newborn will fall under the late enrollment provisions of the CNM Rules.) In either case, you will be granted 61 days from the newborn's date of birth to provide your employer's benefits office with your newborn's birth certificate.**

If the newborn is enrolled within 30 days, the Plan pays benefits for your newborn's services, including newborn visits in the Hospital by the baby's Physician, circumcision, incubator, and routine Hospital nursery charges. If your newborn needs special care including diagnostic tests and Surgery, the Plan pays benefits for that care too. A separate Inpatient Copayment, (or Deductible and/or Coinsurance for Out-of-network care) for your newborn applies only when the infant's Inpatient stay exceeds the mother's date of discharge.

If your newborn stays in the Hospital longer than the mother does, you must notify the Presbyterian Health Plan Customer Service Center by calling (505) 923-7752 or toll-free 1-866-670-0600 before the mother is discharged from the Hospital, to coordinate the baby's care, or benefits may be reduced or denied.

NAPRAPATHIC SERVICES

Any Covered service of a Licensed Naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance. Benefits are subject to a Calendar Year limit as shown in the Summary of Benefits.

NEWBORN AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Plans and insurance issuers may not require that a Provider obtain **Prior Authorization** from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

PHYSICIAN SERVICES

Please refer to the *Summary of Benefits* for applicable Copayments, Deductible and Coinsurance for the following services.

ALLERGY SERVICES

Benefits are available for direct skin (percutaneous and intradermal) and patch allergy tests and radioallergosorbent testing (RAST).

CHRONIC PAIN TREATMENT

Chronic pain treatment is a benefit when used for palliative care administered by a licensed Physician only.

CONTRACEPTIVE DEVICES

Benefits are available for contraceptive devices that require a prescription by a Physician including:

- IUDs; and
- Diaphragms.

If you must obtain the IUD, or a diaphragm from a pharmacy, you will have to pay for the item and then file a claim to Presbyterian Health Plan. All other contraceptive devices that do not require a prescription are not a benefit.

INJECTABLE DRUGS

FDA-approved therapeutic injections administered in a Provider's office are covered. However, certain injectable drugs (such as growth hormone and interferon alfa-2) are covered only when **Prior Authorization** is received from Presbyterian Health Plan. Your Presbyterian Health Plan contracted Provider has a list of those injectable drugs that require **Prior Authorization**. If you need a copy of the list, contact one of our Customer Service Center Representatives. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization,** when required. Failure to do so may result in benefits being denied.

Presbyterian Health Plan reserves the right to exclude any injectable drug currently being used by a Member that is not specifically listed as covered. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a Presbyterian Health Plan Health Services representative if you have any questions about this policy.

INPATIENT PHYSICIAN VISITS AND CONSULTATIONS

Attending Physician visits and consultations in the Hospital are benefits during a covered Admission.

OFFICE VISITS

Benefits are available as outlined in the *Summary of Benefits*.

WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING

Weight loss management, obesity treatment, and nutritional counseling are not benefits unless dietary advice and exercise are provided by a Physician, licensed nutritionist, or registered dietician. Weight loss management, obesity treatment, and nutritional counseling must be prescribed by a licensed Physician and

are a benefit only when Medically Necessary and for a body mass index (BMI - weight in kilograms divided by height in meters squared) of 35 or more. Some Medical services associated with obesity treatment require **Prior Authorization**. If you access care through an In-network Provider, they will obtain **Prior Authorization** when necessary. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Also, see Morbid Obesity.

PREVENTIVE SERVICES

Preventive care services are those Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Benefit payments for services listed in this Section are not subject to Copayments for care obtained from In-network Providers or National PPO Network Providers. If the services listed in this Section are obtained from an Out-of-network Provider, **only** applicable Coinsurance applies (Deductible is waived). The services listed below, including the diagnosis of osteoporosis, are covered.

PREVENTIVE SERVICES FOR WOMEN

Well-woman visits to include adult and female-specific screenings and preventive benefits

- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery
- Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
- Domestic and interpersonal violence screening and counseling for all women.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast-feeding counseling.
- Sexually Transmitted Infections (STI) counseling for sexually active women.
- Sterilization services for women only. Other services during procedure are subject to deductible and coinsurance as outlined in your Summary of Benefits.
- Well –woman visits to obtain recommended preventive services for women under 65.

You can obtain additional information about Women's Preventive Services recommendations and guidelines on our website at www.phs.org and at the HealthCare.gov website at http://www.healthcare.gov/prevention.

Please refer to your formulary on the Pharmacy page at http://www.phs.org/PHP/programs/pharmacy/formulary/index.htm to review the list of contraceptive products that will not apply a copayment/coinsurance

CYTOLOGIC SCREENING (PAP SMEAR SCREENING)
Benefits are available to determine the presence of precancerous or cancerous conditions and other health problems in accordance with the national medical standards for women who are 18 years of age or older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening.

EVIDENCE-BASED ITEMS OR SERVICES
Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Service Task Force (Task Force) with respect to the individual involved.

Immunizations for routine use in children, and adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

HUMAN PAPILLOMAVIRUS (HPV) SCREENING
HPV Vaccine Coverage for the Human Papillomavirus, as approved by the Food and Drug Administration, for females 9 to 26 years of age used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations *in accordance with guidelines established by* The Advisory Committee on Immunization Practices (ACIP).

HEALTH EDUCATION AND COUNSELING
Health education and counseling services will be provided if recommended by your treating Physician and if consistent with Presbyterian Health Plan policy, including:

- If you are 20 years of age or older, you may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. Included in the consultation may be, but not limited to:
  - smoking control;
  - nutrition and diet recommendations;
  - exercise plans;
  - lower back protection;
  - immunization practices;
  - breast self-examination;
  - testicular self-examination;
  - use of seat-belts in motor vehicles; and
  - other preventive healthcare practices.
- If you are under age 20, educational materials or consultation to discuss lifestyle behaviors that promote health and well-being including, but not limited to:
  - the consequences of tobacco use;
  - nutrition and diet recommendations;
  - exercise plans; and
  - as deemed appropriate by the Attending Physician or as requested by the parents or legal guardian for children under 18, educational information on alcohol and substance abuse, sexually transmitted diseases and contraception.

Diabetes self-management education programs are also covered when Medically Necessary.

MAMMOGRAPHY COVERAGE

Benefits are available for low-dose screening mammograms for determining the presence of breast cancer. Guidelines for routine mammography are:

- A baseline before age 40;
- One every 1-2 years for ages 40 and over; and
- As otherwise medically indicated.

PROSTATE EXAMS

Benefits are available for certain prostate tests. Guidelines for prostate exams are:

- One screening every year for men 40 to 50 years of age who are at increased risk of developing prostate cancer; and
- One screening every year for men 50 years of age or older.

ROUTINE VISION SCREENING

Routine vision screenings provided by licensed Providers to determine the need for vision correction are a Covered Service and are limited to screening only for Members through age 19. This does not include routine eye exams or refractions performed by eye care Specialists.

ROUTINE HEARING SCREENING

Routine hearing screenings performed only by licensed Providers to determine the need for hearing correction are a benefit and are limited to screening only for Members through age 19.

ROUTINE IMMUNIZATIONS

Routine immunizations are not subject to Copayments when provided by an In-network Provider, to include flu shots and other covered adult immunizations including pneumococcal vaccine, diptheria/tetanus, meningitis, and hepatitis when clinically appropriate as determined by Presbyterian Health Plan. However, you will be responsible for the appropriate Coinsurance if immunizations are obtained from an Out-of-network Provider. Immunizations for travel are covered. Immunizations for employment are not a covered benefit.

ROUTINE PHYSICAL EXAMINATIONS

This benefit is not subject to an office visit Copayment when provided by an In-network Provider. It provides coverage for routine physical, breast, gynecological and pelvic examinations as well as periodic tests to determine blood hemoglobin, blood pressure and blood glucose level. However, you will be responsible for the appropriate Coinsurance if services are obtained from an Out-of-network Provider.

The following is a suggested schedule for routine physical examinations, after an initial examination:

- Ages 8-19, see Well Child Care (next page);
- Ages 20-39, an exam every 5 years;
- Ages 40-49, an exam every 3 years; and
- Ages 50 and over, an exam every 2 years.

Additional services as recommended by the U.S. Preventive Services Task Force:

- Periodic blood cholesterol, or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level;

- Periodic stool examination for the presence of blood for Members age 40 or older;
- Periodic left-sided colon examination of 35 to 60 centimeters for Members age 45 or older; and
- Periodic glaucoma eye tests for Members age 35 or older.

Employment physicals, insurance examinations, examinations at the request of a third party for premarital; sports, camp, school physicals, international travel and/or other non-preventive services are **not covered**.

The Provider's itemized billing must clearly indicate that the office visit and tests were for preventive care, Well Child Care, or an annual physical to prevent claim payment being made less a Copayment or Deductible and Coinsurance.

WELL-CHILD CARE

Coverage is provided in accordance with the schedule of well-child exams suggested by the American Academy of Pediatrics as follows:

- During first year of age at 1, 2, 4, 6, 9, and 12 months;
- During second year of age at 15, 18, and 24 months; and
- Every year for ages 3 through 18.

ROLFING

Rolfing is a covered benefit that is limited as outlined in the *Summary of Benefits*, in combination with Acupuncture, Chiropractic, and Massage Therapy. Rolfing must be provided by a certified rolfer.

SKILLED NURSING FACILITY

A Skilled Nursing Facility provides room and board and Skilled Nursing services for Medical Care and has one or more licensed nurses on duty at all times supervised on a 24-hour basis by a Registered Nurse (RN) or a Physician, and the services of the Physician are available at all times by an established agreement. The facility must also comply with the legal requirements that apply to its operation, and keep daily medical records on all patients. A Skilled Nursing Facility is not an institution, or part of one, used mainly for rest care, care of the aged, care of substance abuse treatment, Custodial Care, or educational care.

Note:

Prior Authorization is required for Skilled Nursing Facility benefits. This benefit is limited as shown in the *Summary of Benefits*. The Inpatient Copayment is waived if confinement in the Skilled Nursing Facility is within 15 days after release from the Hospital and the stay is subject to continued stay review for Medical Necessity. In-network Providers request **Prior Authorizations** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorizations** with your Physician before obtaining services.

SMOKING CESSATION

Benefits are available for smoking cessation expenses up to a maximum benefit per Member per lifetime as shown in the *Summary of Benefits*. This benefit includes Acupuncture, hypnotherapy and other recognized smoking cessation programs that are covered through the medical portion of the Plan. In order to use this benefit, Members must secure medical services and/or purchase the smoking deterrent and pay for the services and drugs in full. All claims for medical services must then be filed through the medical portion of the Plan using a Member Claim Form.

SURGERY

Benefits are available for the following surgical services:

- Necessary anesthesia services by a qualified Provider;
- Sterilization, but **not** procedures to reverse voluntary sterilization;
- Services of a Physician who actively assists the operating surgeon in the performance of a covered Surgery when the procedure requires an assistant, but **not** services of a Physician who is on standby, or available should services be needed; and
- Second or third opinion consultants. The second opinion must be received within six months of when the procedure was recommended. The third opinion must be received within six months of the date the second opinion was given. The Physician giving the second or third opinion must not be the Physician who recommends or performs the Surgery and must practice in a different office than the Physician who recommends or performs the Surgery.

Cosmetic or plastic Surgery or reconstruction procedures, such as breast augmentation, rhinoplasty, surgical alteration of the eye, and surgical correction of prognathism, that Presbyterian Health Plan determines are not required to materially improve the physiological function of an organ or body part are **not** Covered Services. Services for the reconstruction of surgically induced scars are not benefits under any circumstances. Also, additional Surgery or treatment required to care for or to correct a complication due to a previous Surgery is **not** a benefit.

Also, most surgeries require a **Prior Authorization.** In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician.

CARDIAC SURGERY

Benefits are available for cardiac Surgery such as those for valve replacements or pacemakers.

CATARACT SURGERY

Benefits are available for cataract Surgery. The initial placement of either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) will be a covered service.

Contact lenses are also available when necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or ocular injury or prescribed by a Physician as the only treatment available for keratoconus. Services must be Medically Necessary and further replacement is covered only if a Physician or optometrist recommends a change in prescription. Replacement due to wear, loss or damage is not a covered benefit.

COCHLEAR IMPLANTS

Cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device, is covered.

CONGENITAL ANOMALIES

Benefits are available for the surgical correction of functional anomalies present from birth. There are **no** benefits for cosmetic procedures or procedures that are **not** Medically Necessary.

MORBID OBESITY

Benefits are available for surgical treatment of morbid obesity (bariatric Surgery) **only** when prescribed by a licensed Physician, when Medically Necessary, and with a body mass index (BMI - weight in kilograms divided by height in meters squared) of 35 or more. **Prior Authorization** may be required from Presbyterian Health Plan prior to services being rendered. If you access care through an In-network Provider, they will obtain **Prior Authorization,** when necessary. If you access care from an Out-of-network Provider or National PPO Network Provider, you will have to **obtain Prior Authorization.** Failure to do so may result in benefits being reduced or denied. Also, see Weight Management.

ORAL SURGERY

See "Dental Care and Medical Condition of the Mouth and Jaw" in this section.

OUTPATIENT SURGERY

Benefits are available for Medically Necessary surgical procedures performed in an Outpatient setting (there is no Hospital Admission).

RECONSTRUCTIVE SURGERY

Benefits are available for certain types of reconstructive Surgery needed to restore or correct the function of a body part damaged by illness or Accidental Injury.

Reconstructive Surgery that is required because of an Accidental Injury or breast reconstruction subsequent to a mastectomy (breast removal) required as a consequence of disease, is a benefit.

MASTECTOMY SERVICES

Medically necessary hospitalization related to a covered mastectomy, including at least 48 hours of Inpatient care following a mastectomy and 24 hours following a lymph node dissection is covered.
When breast reconstruction is chosen, Covered Services include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetry between the two breasts, including nipple reconstruction; and
- Prostheses and physical complications in all stages of mastectomy, including lymphdemas as determined by the Attending Physician and the patient.

Breast reconstruction Surgery is limited to a surgical procedure or procedures performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts. Benefits are also available for procedures related to nipple reconstruction following a mastectomy.

Removal of breast **Prosthesis** is a covered benefit when deemed Medically Necessary. Replacement of the **Prosthesis** is **not** a covered benefit if original placement was due to a cosmetic procedure. Reduction mammoplasty Surgery is covered if the patient meets all the criteria to establish medical necessity.

NOTE:
If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in Section 5 – Filing Claims.

THERAPY

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Benefits are limited as shown in the *Summary of Benefits* for combined visits per Calendar Year for Outpatient rehabilitation services including physical therapy from a licensed Physical Therapist, and occupational or speech therapy from a licensed or certified therapist. Benefits are **not** available for speech therapy in connection with learning disabilities.

These services may also include treatment using cold, heat, or similar modalities to relieve pain, restore maximum function, and prevent disability following illness, Accidental Injury, or loss of a body part.
Benefits are **not** available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

RESTORATIVE SPEECH THERAPY

Restorative speech therapy, in conjunction with a covered illness or injury, includes an additional benefit through the Plan to restore speech. Benefits are limited as shown in the *Summary of Benefits*.

To be eligible for this additional coverage, the Member must have a documented potential for improvement. This therapy excludes coverage for Members with normal physical development but having speech intelligibility limitations. Also excluded are stuttering conditions and Maintenance Therapy.

NOTE:
If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in Section 5 – Filing Claims.

TRANSPLANT SERVICES

Transplant services include a surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Organ transplant services include the recipient's medical, surgical and Hospital services; Inpatient Immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants; kidney/pancreas, kidney, liver, lung, pancreas, intestine, or small bowel/liver. Also covered are islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be Medically Necessary. Effective January 1, 2007, corneal transplants are also covered. To be covered, transplant services must also be received within one year of the transplant or re-transplant.

Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgery."

The treating Physician or Member must obtain **prior approval** from Presbyterian Health Plan before benefits for any transplant procedure is provided. **Prior Authorization** must be obtained from Presbyterian Health Plan before a pretransplant evaluation is scheduled. A pretransplant evaluation is **not covered** if **Prior Authorization** is not obtained from Presbyterian Health Plan. A Presbyterian Health Plan case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the

results of the evaluation. In-network Providers request **Prior Authorization** for you. Discuss the need for **Prior Authorizations** with your Physician before obtaining services.

If you are approved as a transplant recipient candidate, you must ensure that **Prior Authorization** for the actual transplant is also received. None of the benefits described here are available unless you have this **Prior Authorization**.

In addition, benefits are available **only** when the transplant is performed at a facility with a transplant program approved by Presbyterian Health Plan. Call our Customer Service Center at (505) 923-7752 or toll-free at 1-866-670-0600, TTY users may call 711 for a current list of Presbyterian Health Plan approved programs.

Affect of Medicare Eligibility on Coverage: If you are now eligible for or are anticipating receiving eligibility for Medicare benefits, you are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses: If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires Surgery to make an organ available for a covered transplant (e.g., kidney or liver), coverage is available for expenses incurred by the donor for travel (if required, covered under the "Transplant" provision, and approved by the Presbyterian Health Plan case manager), Surgery, organ storage expenses, and Inpatient follow-up care only.

This Plan does not cover donor expenses after the donor has been discharged from the transplant facility.

Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Covered Services related to the transplants are subject to usual cost-sharing features and benefit limitations of this Plan (e.g., Copayments, Deductible/Coinsurance, and Out-of-pocket limits; annual home healthcare maximums).

Reminder:
Benefits are available **only** when the transplant is performed at a facility with a transplant program approved by Presbyterian Health Plan.

Travel expenses incurred by you in connection with a prior approved organ/tissue transplant are covered subject to the following conditions and limitations. Benefits for transportation, lodging and food are available to you only if you are the recipient of a prior approved organ/tissue transplant from a Presbyterian Health Plan approved Organ Transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation; (b) candidacy; (c) transplant event; or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

- Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- Lodging while at, or traveling to and from transplant site; and
- Food while at or traveling to and from the transplant site.
- Travel must occur within five days prior or no more than one year following the actual transplant.

In addition to you being covered for the charges associated with the item above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a Member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

By way of example, but not of limitation, the following are specifically excluded travel expenses:

- Travel costs incurred due to travel within 60 miles of your home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products;
- Charges for transportation that exceed coach class rates; and
- These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Travel benefits are available for an adult transplant recipient and one other person or for a transplant patient who is a minor; benefits are available for two adults. Transportation costs will be covered only if travel beyond 60 miles of your home is required. Reasonable expenses for lodging and meals will be covered, up to a maximum of $125 per day for each person. All benefits for transportation, lodging, and meals are limited to a maximum payment of $10,000.

Benefits are **not** available for implantation of artificial organs, mechanical devices or for non-human organ transplants and those services otherwise listed as covered elsewhere in this booklet. Follow-up care and complications of non-covered transplants are **not** a covered benefit.

Benefits are subject to the same Copayment, Coinsurance and Out-of-pocket Maximum provisions as other benefits. The cost-sharing provisions of the coverage in effect on the date services are rendered apply to the transplant benefits.

LIMITATIONS AND EXCLUSIONS

Please read this Section carefully. It identifies the limitations that apply to certain Covered Services and specifies the Healthcare Services and supplies that are **not covered** under this Plan.

NOTE:
If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a complaint. You may also request an external review of the Presbyterian Health Plan decision at any time. See "Grievance Procedures" in Section 5 – Filing Claims.

LIMITATIONS

The following benefits have limits applied:

Acupuncture treatment benefits are limited to a Calendar Year maximum of 30 visits per Calendar year per Member for covered expenses, in combination with services provided for chiropractic, massage therapy, and Rolfing.

Autism Spectrum Disorder- Service received under the federal individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three (3) to twenty-two (22) years of age who have Autism Spectrum Disorder are not covered under this plan.

Behavioral Health services (Inpatient) require **Prior Authorization** to be considered an eligible expense under this plan.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Bereavement counseling is limited to three (3) visits in conjunction with services provided through Hospice for a Terminally Ill Member.

Biofeedback treatment is limited to services for Raynaud's disease/phenomenon, urinary incontinence, chronic pain, tension headaches, migraines, craniomandibular joint, and temporomandibular joint (CMJ/TMJ) disorders. Biofeedback is a benefit only when provided by a Physician, a Doctor of Osteopathy, a professional Psychologist, or a Board-Certified Biofeedback Therapist.

Chiropractic (manipulations) services are limited to a Calendar Year maximum benefit of 30 visits per Calendar year per Member for covered expenses, in combination with services provided for Acupuncture, massage therapy, and Rolfing.

Cochlear implants and related care are limited to implantation of a hearing device to facilitate communication for the profoundly hearing impaired, including any necessary training required to use the device.

Consumable medical supplies are covered during hospitalization. They are also covered during an office visit or authorized home health visit. Presbyterian Health Plan does **not cover** supplies used at other times by the Member or Member's family. Consumable medical supplies are: (1) usually disposable; (2) cannot be used repeatedly by more than one individual; (3) are primarily used for a medical purpose; (4) generally are useful only to a person who is ill or injured; and (5) are ordered or prescribed by a licensed Provider.

Contact lenses or eyeglasses (one set) are limited to services necessary to replace lenses absent at birth, lost through cataract or other intraocular Surgery, or prescribed by a Physician as the only treatment available for keratoconus. Duplicate lenses are **not covered** and replacement is covered only if a Physician or optometrist recommends a change in prescription due to the medical condition.

Dental prosthesis, craniomandibular joint (CMJ) and temporomandibular joint (TMJ) disorders, pediatric anesthesia and oral Surgery benefits may require **Prior Authorization** or no benefits may be payable through the Plan. Also, this Plan covers only those procedures listed as covered benefits. This Plan does not cover any other oral or dental procedures such as, but not limited to:

- Some services where **Prior Authorization** is not obtained from Presbyterian Health Plan (except initial treatment of Accidental Injuries).
- Nonstandard services (diagnostic, therapeutic, or surgical).
- Dental treatment or Surgery, such as extraction of teeth (including wisdom teeth) or application or cost of devices or splints, unless required due to an Accidental Injury.
- Removal of impacted teeth; removal of tori or exostoses; procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures.
- Duplicate or "spare" appliances.
- Artificial devices and/or bone grafts for denture wear.
- Personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Diabetic supplies and services that require **Prior Authorization**: Podiatric and Orthopedic Appliances.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a MP Provider, then it is your responsibility to obtain a Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Diagnostic testing for infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the Plan determines that the recommended treatment is **not covered**, no further testing will be covered under this Plan.

Family planning coverage is limited to Depo-Provera injections, diaphragms, insertion and removal of birth control devices, intrauterine devices (IUDs), prenatal genetic testing, and sterilization procedures.

Hearing Aids are covered, but the coverage is limited as follows:

- Hearing aids and the evaluation for fitting of hearing aids are covered for children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months "per hearing impaired" ear, thereafter member pays 90% Coinsurance. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit.
- All other members – Hearing aids benefits are limited to a maximum of $500 in benefit payments during any 36-month period, thereafter member pays 90% Coinsurance. This benefit does not include coverage for hearing test or any charge related to the fitting or prescribing of the hearing aid. This 36-month period is not based on a Calendar Year. The 36-month period begins on the date you purchase your first hearing aid and ends 36 months later. This benefit does include repair and replacement of hearing aids.

Home health care services require **Prior Authorization** or no benefits are payable through the Plan.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Hospice care benefits are limited to patients who are Terminally Ill as described in Section 3 – Covered Services. **Prior Authorization** from the Plan is required. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Infertility testing is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the Plan has determined that treatment is **not covered** by this Plan, no further testing will be covered.

Infertility treatment is limited to Surgery to open obstructed tubes, epididymis or vasectomy when not the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency.

Massage therapy is limited to a Calendar Year maximum benefit of 30 visits per calendar year per Member for Covered Services, in combination with services provided for Acupuncture, chiropractic services, and Rolfing**.** In addition, in order for services to be covered under this Plan, a Physical Therapist, Licensed Massage Therapist, Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or a Chiropractor must provide services.

Naprapathic Services Are limited to $500 per Calendar year. Services are covered In-Network only. Any Covered service of a Licensed Naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance. Benefits are subject to a Calendar Year limit as shown in the Summary of Benefits

Physical, occupational and speech therapy these services also require **Prior Authorization**.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Preventive services are limited as listed on the *Summary of Benefits* and suggested frequency schedules in Section 3 – Covered Services.

Reconstructive Surgery requires **Prior Authorization** or no benefits are payable through the Plan.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member's condition, or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan.

If you obtain services from an In-network Participating Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Respite care for a Hospice caretaker will be limited up to 10 days maximum per hospice period, two (2) hospice periods per lifetime.

Rolfing is limited to a Calendar Year maximum benefit of 30 visits per Calendar year per Member for Covered Services, in combination with services provided for Acupuncture, chiropractic services, and massage therapy.

Routine eye screenings are limited to Dependents through age 19.

Routine hearing screenings are limited to Dependents through age 19.

Skilled Nursing Care is limited to **60 days per Calendar Year** and is subject to **Prior Authorization** by Presbyterian Health Plan. If you access care from an Out-of-Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Substance Abuse benefits are limited as follows: Services for any combination of Inpatient and partial hospitalization benefits is limited to 30 days per Calendar Year for substance abuse services, and there is a lifetime maximum of two courses of treatment for all services combined. Outpatient services are limited to 30 visits per Calendar Year for Substance Abuse benefits. All Inpatient services require **Prior Authorization** to be considered an eligible expense under this Plan

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Lifetime maximum of 30 inpatient days per year for substance abuse treatment for all services combined, including inpatient and outpatient services.

Transplants - Benefits for travel, lodging, and meals are limited to an adult transplant recipient and one other person. For minor children, benefits are payable for two adults. Lodging and meals are limited to $125 per day per person, including the transplant patient, to a maximum lifetime benefit payment of $10,000, to include transportation. Donor organ procurement costs for the surgical removal, storage, and transportation of the donated organ are covered for Medicare allowable Charges.

EXCLUSIONS

Any service, supply, item or treatment not listed as a covered service in Section 3 – Covered Services, is **not covered** under this Plan. Benefits are not available for any of the following services, supplies, items, situations, or related expenses:

Activities of daily living are not a covered benefit, to include assistance in bathing, dressing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.

Admissions/Treatments Discontinued by Patient including charges associated with any episode of alcoholism or drug abuse for which the patient did not complete the prescribed continuum of care may not be covered under this Plan.

Adoption/Surrogate expenses are not a covered benefit.

Ambulance (including air ambulance) charges which are not Medically Necessary.

Amniocentesis and/or ultrasound to determine the gender of a fetus are **not covered** benefits under this Plan.

Artificial conception including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as artificial insemination, in-vitro ("test tube") or in-vivo fertilization, GIFT, ZIFT, all drugs, hormonal manipulation, donor sperm or embryo transfer are **not** Covered Services. Any artificial conception method not specifically listed is also excluded.

Autopsies are not a covered benefit under this Plan.

Before effective date benefits are not available for that portion of any Inpatient treatment provided before the Member's effective date or for any service or supply received before the Member's effective date under this Plan.

Behavioral disorders are not a covered benefit under this Plan unless associated with a manifest mental disorder.

Behavioral Health and Alcoholism and/or Substance Abuse for the following are **not covered**:

- Any care which is patient elected and is not considered Medically Necessary;
- Care which is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider;
- Workers' Compensation or disability claims are **not covered** as part of treatment;
- Long term Custodial Care of children and adolescents;
- Special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or education and developmental disorders;
- Behavioral problems unless associated with manifest mental illness or other disturbances; and
- Non-national standard therapies, including Experimental as determined by the Behavioral Health professional practice.

Behavioral training is not a covered benefit under this plan.

Blood charges if the blood has been replaced and blood donor storage fees if there is not a scheduled procedure.

Charges

- In excess of Plan limits.
- In excess of Medicare allowable amounts when services are secured from an Out-of-network Provider.
- Made by a family Member (spouse, parent, grandparent, sibling or child) or someone who lives with you.

Clinic or other facility services that the Member is eligible to have provided without charge.

Complications of non-benefit services, supplies and treatment received including, but not limited to, complications for non-covered transplants, cosmetic, Experimental, or Investigational procedures, sterilization reversal, infertility treatment, or gender changes are **not** Covered Services.

Contact lenses or eyeglasses unless specifically listed as a covered benefit under this Plan.

Convalescent care or rest cures.

Cosmetic Surgery is not Covered. Examples of Cosmetic Surgery include, but are not limited to, breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except when used for truncal veins), and nasal rhinoplasty.

Counseling services are not a covered benefit under this Plan unless listed as a covered service.

Court ordered services are not a covered benefit under this Plan.

Custodial Care such as sitters, homemaker's services, or care in a place that serves the patient primarily as a residence when the Member does not require Skilled Nursing Care.

Custom-Fabricated knee-ankle-foot orthoses (AFO and/or KAFO) except for Members up to eight years old when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

Dental services to include periodontal Surgery except if the services required are due to Accidental Injury of sound natural teeth or as otherwise listed as a covered Benefit under this Plan.

Dependent of Dependent (grandchild) expenses are **not covered** benefits unless the Dependent is otherwise eligible for coverage under this Plan.

Diagnostic testing for infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the treatment is determined to be **not covered** by this Plan, no further testing will be covered under this Plan.

Diagnostic, therapeutic, rehabilitative or health maintenance services provided at or by a health spa or fitness center, even if a licensed or registered Provider provides the service.

Domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Donor expenses incurred by a Member are not a covered benefit under this Plan, except as specified in this Summary Plan Description.

Duplicate coverage including, but not limited to:

- Services already covered by other valid coverage;
- Services already paid under Medicare or that would have been paid if the Member was entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits; if your prior coverage has an extension of benefits provision, this Plan will not cover charges incurred after your effective date under this Plan that are covered under the prior plan's extension of benefits provision.

Duplicate diagnostic tests or over reads of laboratory, pathology, or radiology tests are **not covered**.

Duplicate equipment is **not covered** under this Plan.

Durable Medical Equipment, orthotic and Prosthetic Devices and external prostheses repairs for items not owned by the Member, or which exceed the purchase price.

Educational or institutional services except for diabetes education and preventive care provided under routine services as described in Section 3 – Covered Services.

Environmental control expenses are **not covered** benefits under this Plan.

Exercise equipment is not a covered benefit under this Plan.

Experimental or Investigational services/treatment are **not covered** benefits. Experimental or Investigational means any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and **not** Experimental or Investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate governmental regulatory bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvements must be attainable outside the Investigational settings.

Eye exercises and refractions are not a covered benefit under this Plan.

Food and lodging expenses are **not covered** except for those that are eligible for per diem coverage under the "Transplant Services" provision in Section 3 – Covered Services.

Foot care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone Surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails, unless medical conditions such as diabetes exist.

Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, and other conditions (as determined by Presbyterian Health Plan) are **not covered**, except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Genetic Testing or Counseling including tests such as amniocentesis or ultrasound to determine the sex of an unborn child are **not covered** under this Plan.

Hair loss, including wigs, artificial hairpieces, hair transplants, or implants, even if there is a medical reason for hair loss.

Hearing aids

- Hearing aids and the evaluation for fitting of hearing aids are covered for children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months "per hearing impaired" ear, thereafter member pays 90% Coinsurance. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit.

- All other members – hearing aids benefits are limited to a maximum of $500 in benefit payments during any 36-month period, thereafter member pays 90% Coinsurance. This benefit does not include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. This 36-month period is not based on a Calendar Year. The 36-month period begins on the date you purchase your first hearing aid and ends 36 months later. This benefit does include repair and replacement of hearing aids.

Home health care benefits for care that:
- Is provided primarily for the convenience of the Member or the Member's family;
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter; or
- Is provided by a nurse who ordinarily resides in the Member's home or is a Member of the patient's immediate family.

Hospice benefits are not available for the following services:
- Food, housing, or delivered meals;
- Medical transportation;
- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing;
- Pastoral and spiritual counseling.
- Volunteer services; and
- Support services provided to the family when the patient is not a Member of this Plan.

Additionally, the following services are not benefits under **Hospice** but may be covered elsewhere under this booklet:
- Acute Inpatient Hospital care for curative services;
- Durable Medical Equipment;
- Non-Hospice care Physician visits; and
- Ambulance Services.

Human Chorionic Gonadotrophin (HCG) injections are not a covered benefit under this Plan.

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered under "Smoking Cessation Treatment."

Implantation of artificial organs or mechanical devices, except as specified in this booklet, are not a covered benefit under this Plan unless as a result of illness or injury and **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Infertility testing and treatment is not a covered benefit under this Plan. Also, see the exclusion under Artificial Conception.

Intradiscal Electrothermal Therapy (IDET) is not a covered benefit under this Plan.

Late claims filing: This Plan does not cover services submitted for benefit determination if Presbyterian Health Plan receives the claim **more than 12 months** after the date of service. Note: If there is a change in the Claims Administrator, the length of this timely filing period may also change.

Learning disabilities and behavioral problems: This Plan does not cover special education, counseling, therapy, or care for learning or behavioral problems.

Legal payment obligations: Services for which the Member has no legal obligation to pay or that are free, charges made only because benefits are available under this Plan, services for which the Member has received a professional or courtesy discount, services provided by the Member upon oneself or a covered family Member, or by one ordinarily residing in the Member's household, or by a family Member, or Physician charges exceeding the amount specified by the Health and Human Services Department when benefits are payable under Medicare.

Local anesthesia charges that have been included in the cost of the surgical procedure are **not covered**.

Long-term rehabilitation services are **not covered**. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is **not covered**.

Maintenance or long-term therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice benefit period) is **not covered** under this Plan. In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Physician supporting his/her opinion that your rehabilitative potential has not been reached. Note: Even if your rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations.

Massage therapy is **not covered** under this Plan unless performed by a Licensed Physical Therapist, Licensed Massage Therapist, medical doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

Medical equipment unless listed as a covered item under this Plan.

Medically unnecessary services: This Plan does not cover services that are not Medically Necessary as defined in the beginning of Section 3 – Covered Services, unless such services are specifically listed as covered (e.g., see "Preventive Services).

Membership fees are not a covered benefit under this Plan.

Meniscal Transplants are not a covered benefit under this Plan.

Mobile or temporary testing units who submit a bill to this Plan will have those charges denied, to include services for pap smears, OB/GYN services, adult general screenings and physicals.

Non-covered Providers: Members of your immediate family or one normally residing in your home, health spas or health fitness centers, school infirmaries (except for Student Health Centers at institutions of higher

education), private sanitariums, nursing homes, rest homes, or dental or medical departments sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

Non-human organ transplants are **not covered** under this Plan

Non-medical equipment is **not a covered** benefit under this Plan.

Non-medical expenses: This Plan does not cover non-medical expenses (even if medically recommended and regardless of therapeutic value), including charges for services such as, but not limited to: missed appointments, "get-acquainted" visits without physical assessment or Medical Care, the provision of medical information to perform pre-Admission or concurrent review, filling out of claim forms, mailing and/or shipping and handling charges, interest expenses, copies of medical records, modifications to home, vehicle, or workplace to accommodate medical conditions, voice synthesizers, other communication devices, Membership fees at spas, health clubs, or other such facilities even if medically recommended.

Nonprescription and over the counter drugs as well as:

- Infertility medications;
- Non-medicinal substances, regardless of intended use;
- Medications or preparations used for cosmetic purposes, such as preparations to promote hair growth or medicated cosmetics; or
- Charges for the administration or injection of any drug, including allergens or allergy shots unless elsewhere covered in this booklet.

Non-prescription vitamins, dietary/nutritional supplements, special foods, formulas, or diets.

Nonstandard or deluxe equipment is not a covered benefit under this Plan.

Nutritional supplements are not a covered benefit under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a covered benefit.

Obesity treatment is not a covered benefit under this Plan unless the Member is being treated for morbid obesity.

Orthodontic appliances and treatment, crowns, bridges, or dentures for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders unless the disorder is trauma related. Also, nonstandard diagnostic, therapeutic and surgical treatments of TMJ are not benefits under any circumstances.

Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints are **not covered**, except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Orthoptics are not a covered benefit under this Plan.

Orthotripsy is not a covered benefit under this Plan.

Over the counter contraceptive medications and supplies are not a covered benefit under this Plan.

Personal convenience items such as air conditioners, humidifiers, or physical fitness exercise equipment, or **personal services** such as haircuts, shampoos and sets, guest meals, and radio or television rentals are **not covered**.

Personal trainers are **not covered** under the provisions of this Plan.

Physical examinations and/or immunizations for purposes of employment, insurance, premarital or international travel tests, sports, school, camp, other non-preventive tests, and those requested by a third party, are **not covered** under this Plan unless considered Medically Necessary by the Plan.

Post-termination care: Except as otherwise required by applicable law this Plan does not cover services received after your coverage is terminated, even if **Prior Authorization** for such services were needed because of an event that occurred while you were covered.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

Prescription drugs: For each Prescription Drug/Medication purchased at our Participating Pharmacy, one applicable Preferred Generic, Preferred Brand or Non-preferred Drug Cost Sharing Copayment will be required per 30-day supply up to the maximum dosing recommended by the manufacturer/FDA. When available, FDA approved generics will be dispensed regardless of the brand name indicated.

Private-duty nursing charges are **not covered** under this Plan unless services are considered Medically Necessary.

Private room expenses are not a covered benefit under this Plan unless there is documented medical necessity.

Protective clothing or devices are **not covered** under this Plan.

Radial keratotomy, LASIK and other eye refractive surgeries are **not covered** benefits under this Plan.

Reversals of surgical procedures are not a covered benefit under this Plan.

Self-help programs and therapies not specifically covered in this booklet, such as behavior modification; music, art, dance, recreation and Z therapy; massage therapy except when performed by a Licensed Physical Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

Services not specifically identified as a benefit in this booklet, or **services not listed as a covered benefit** in this booklet.

Sex-change operations and reversals of such procedures are **not covered** benefits**.**

Sexual dysfunction testing and treatment, unless related to organic disease or Accidental Injury.

Speech therapy charges not otherwise listed as a covered benefit under this Plan.

Sperm storage is not a covered benefit under this Plan.

Standby professional services are **not covered** under this Plan.

Surgical sterilization reversal of voluntary infertility procedures is **not covered** under this Plan.

Thermography (a technique that photographically represents the surface temperatures of the body) is **not covered** under this Plan.

Transplants not specifically listed as a covered benefit under this Plan are **not covered**.

Travel and other transportation expenses, except as covered under "Ambulance Services" and "Transplants" are **not covered**.

Treatment for injuries sustained by a Member in the course of committing a felony, if the Member is subsequently convicted of the felony is **not covered**.

Unreasonable charges will not be covered by this Plan.

Untimely filing: Claims filed more than 12 months after the date of service are **not covered**.

Veterans Administration facility services or supplies furnished by a Veterans Administration facility for a service-connected disability, or while a Member is in active military service are **not covered**.

Vision care: The Plan does not cover eyeglasses, contact lenses, and routine eye refractions unless listed as covered in this booklet.

Vision therapy or any surgical or medical service or supply provided in connection with refractive keratoplasty (Surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct myopia, or any procedure to correct refractive defects such as farsightedness, presbyopia, or astigmatism are **not covered**.

Vitamins, dietary/nutritional supplements, special foods, formulas, or diets are **not covered** under this Plan.

Vocational rehabilitation services are not a covered benefit under this Plan.

War-related conditions: This Plan does not cover any services required as the result of any act of war, or any illness or Accidental Injury sustained during combat or active military service.

Weight-loss programs, obesity treatment, and nutritional counseling, except as outlined in Section 3 - Covered Services.

Work-related conditions: This Plan does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- Occupational disease laws;
- Employer's liability;
- Municipal, state, or federal law (except Medicaid); or
- Workers' Compensation Act.

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (Presbyterian Health Plan may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

This Plan does not cover a work-related illness or injury, even if:

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

NOTE:
This "Work-related condition" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and that you are eligible for the waiver. (The Workers Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

FILING CLAIMS

As a Member of this Plan, for payment to be made you will generally **not** have claims to file or papers to fill out for medical services obtained from In-network Providers. In-network Providers will bill Presbyterian Health Plan directly. On occasion you may access care from a non-contracted provider such as in an emergency when you are traveling out of the Service Area. In such cases you may have to file a claim yourself.

EMERGENCY SERVICES OR OUT-OF-NETWORK PROVIDERS

In some cases Hospital, laboratory, x-ray, and clinic claims are filed by the Out-of-Network Providers, as well as In-network. Out-of-network Physicians may also file claims for you.

You will be required to submit claim forms when your Out-of-network Provider does not file them for you. Submit all claims as the services are received and attach the itemized bill for services or supplies. Do not file for the same service twice unless requested by one of our Customer Service Center Representatives.

The Member Claim Forms are available from your benefits representative, or one of our Customer Service Center Representatives. They can also be printed out from our website at www.phs.org. Please mail the claim forms and itemized bills to:

Presbyterian Health Plan, Inc.
Attn: CNM Claims
P.O. Box 27489
Albuquerque, NM 87125-7489

Claims must be submitted no later than 12 months after the date a service or supply was received. If your provider does not file a claim for you, you are responsible for filing the claim within the 12-month deadline. **Claims submitted after the 12-month deadline are not eligible for benefit payments.** If a claim is returned for further information, you must resubmit it within 90 days.

OUT-OF-NETWORK SERVICE CLAIMS

When you obtain Physician or Outpatient Hospital services from an Out-of-network Provider, the Physician, Hospital, or you should file the claims with Presbyterian Health Plan. If the Physician or Hospital does not file the claims, ask for an itemized statement and complete it the same way that you would for services received from an Out-of-network Provider. Payments for these services may be required to be made by **you**.

CLAIMS OUTSIDE THE UNITED STATES

Even overseas, this Plan's coverage travels with you. If you need Hospital or Physician care, claims should be handled the same way as described in "Out-of-network Claims," above. Members are responsible for ensuring that claims are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States.

ITEMIZED BILLS

Itemized bills must be submitted on billing forms or letterhead stationery and must show:

- Name and address of the Physician or other healthcare provider;
- Full name of the patient receiving treatment or services; and
- Date, type of service, diagnosis, and charge for each service separately.

The only acceptable bills are those from healthcare providers. Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills are not returned to you. Itemized bills are necessary for your claim to be processed so that all benefits available under this Plan are provided.

If your itemized bill(s) include services previously filed, identify clearly the new charges that you are submitting.

HOW PAYMENTS ARE MADE

Payments to Out-of-network Providers are sent to the Member unless the Member has assigned benefits to the provider. When possible, this Plan will honor an assignment of benefits; however, Presbyterian Health Plan reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits to pay anyone other than the subscriber in any circumstances.

Provider payments are based upon In-network Provider agreements and the Negotiated Fee for Service as determined by Presbyterian Health Plan. You are responsible for paying all Copayments, Coinsurance, and non-Covered Services.

If you obtain services from an Out-of-Network Provider, you are responsible for any amounts greater than Medicare allowable amounts. You are also responsible for paying all Copayments, Deductibles, Coinsurance, and non-covered services.

Payment of benefits for Members eligible for Medicaid is made to the New Mexico Human Services Department or to the Medicaid provider when required by law.

Additional information may be requested to process your claim, coordinate benefits, or protect the subrogation interest. You must supply the information or agree to have the information released by another person to Presbyterian Health Plan.

You may be requested to have another Physician examine you if there are questions about a **Prior Authorization** review or about a particular service or supply for which you are claiming benefits. In this event, the Plan will cover the requested examination.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

OVERPAYMENTS

If payments made by Presbyterian Health Plan are greater than the benefits you have under this Plan, you are required to refund the excess. In the event that you do not, future benefits may be withheld and applied to the amount that you owe to Presbyterian Health Plan.

COORDINATION OF BENEFITS

This Plan contains a Coordination of Benefits (COB) provision that prevents duplication of payments. Under this provision, if a Member is eligible for healthcare benefits under any other valid coverage, the combined benefit payments from all coverages cannot exceed 100% of the covered expenses. *Other valid*

coverage means all other insurance policies, which may include Medicare, that provide payments for medical expenses.

If a Member is covered by both Medicare and this Plan and is not a retiree, special COB rules may apply. Contact one of our Customer Service Center Representatives for more information.

If a Member is currently covered under COBRA provisions, coverage ceases at the beginning of the month in which the Member either becomes enrolled for any other valid coverage, or until the COBRA period expires, whichever occurs first.

The following rules determine order of benefit determination between this Plan and any other plan covering a Member not on COBRA continuation on whose behalf a claim is made:

1. No COB Provision. If the other valid coverage does not include a COB provision, that coverage pays first and this Plan pays secondary benefits.

2. Employee/Dependent. If the Member who received care is covered as the employee under one plan/coverage and as a Dependent under another, the employee's coverage pays first. If the Member is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent of an active employee, then the order of benefit determination is:
   a. Benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent
   b. Medicare
   c. Benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired employee.

   If the Member has other valid coverage, please contact the other carrier's Customer Service Department to determine if that coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.

3. Dependent Child/Parents Not Separated or Divorced. If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the other valid coverage does not follow the birthday rule, then the gender rule applies (that is, the male parent's coverage pays first).

4. Child/Parents Separated or Divorced. If two or more plans cover a Member as a Dependent child of divorced or separated parents, benefits for the child follow these rules:
   a. Court-Decreed Obligations. Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's healthcare expenses, the coverage of that parent pays first.
   b. Custodial/Non-Custodial. The plan of the parent with custody of the child pays first. The plan of the spouse of the parent with custody of the child pays second. The plan of the parent not having custody of the child pays last.
   c. Joint Custody. When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans covering

the child follow the order of benefit determination rules applicable to children whose parents are not separated or divorced.

5. Active/Inactive Employee. If the Member who received care is covered as an active employee under one plan/coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a Member is covered as the Dependent of an active employee under one plan/coverage and as the Dependent of the *same* but *inactive* employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

6. Longer/Shorter Length of Coverage. When none of the above applies, the coverage in effect for the longest continuous period of time pays first. The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in the entity that pays, provides, or administers the plan's benefits or a change from one type of plan to another.

If you receive more than you should have when benefits are coordinated, you are required to repay any overpayment.

Your other valid coverage may be with a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or another program that limits or excludes benefits if you do not meet the obligations for obtaining **Prior Authorization** of care, for obtaining the proper level of care for the condition treated or for obtaining services from providers authorized or recognized by your primary carrier. If you do not meet these obligations and your primary benefits are reduced as a result, Presbyterian Health Plan limits its secondary benefit payment to the difference between the Presbyterian Health Plan Negotiated. Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations recognized by your primary carrier.

If you obtain services from an In-network Provider, they will request Prior Authorizations from Presbyterian Health Plan, when required. If you obtain services from a National PPO Network Provider, then it is your responsibility to obtain Prior Authorization, when required. If you fail to obtain Prior Authorization when required, benefits will be administered at the Out-of-network level.

EFFECT OF MEDICARE ON BENEFITS

Shortly before you or your spouse becomes age 65, or if you or any other family Member becomes qualified for Medicare benefits, contact your local Social Security office to establish Medicare eligibility. Then, contact your agency group representative to discuss coverage options.

If you are a working employee age 65 or over and your spouse is age 65 or over, you are eligible to continue the CNM coverage on the same basis as Members under age 65.

When a retiree becomes eligible for Medicare, Medicare is primary and benefits are paid according to the Coordination of Benefits provisions of this Plan.

If Medicare coverage coexists with this Plan, Medicare will be secondary until the Plan pays primary for at least 30 months from the date the Member became eligible for or entitled to Medicare on the basis of end-stage renal disease. A person eligible under Medicare is defined as an employee or Dependent who is enrolled and covered under the voluntary portion (Part B) of Medicare, or who has been eligible to enroll

under such part. All individuals who are eligible to enroll for Medicare Part B but have not done so, will be treated the same as all other persons eligible under Medicare and Presbyterian Health Plan will assume that eligible Members have Part B coverage. Plan benefits will be offset with Medicare Part B benefits whether or not the Member actually receives them.

EFFECT OF MEDICAID ON BENEFITS

Benefits payable on behalf of a Member who is qualified for Medicaid is made to the New Mexico Human Services Department or to the Medicaid provider when required by law.

SUBROGATION

When this Plan pays for your care and you have the right to recover those expenses from the person or organization causing your illness or Accidental Injury, Presbyterian Health Plan has the right of subrogation to recover the amount it has paid. This right of subrogation against the third party may be exercised even if you do not file a legal action. The right of subrogation applies whether you recover directly from the wrongdoer or from the wrongdoer's insurer, or from your uninsured motorist insurance coverage. This applies to all moneys a Member may receive from any third party or insurer, or from any uninsured or underinsured motorist insurance benefits, as well as from any other person, organization or entity.

You have the legal obligation to help recover the amounts paid, and you must do nothing that would prejudice Presbyterian Health Plan's subrogation right. You must notify Presbyterian Health Plan if you file a claim, consult an attorney, or bring action against a third party. If contacted by Presbyterian Health Plan, you must provide all requested information. Settlement of a controversy without prior notice to Presbyterian Health Plan is a breach of this agreement. In the event that you fail to cooperate with Presbyterian Health Plan or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of Presbyterian Health Plan, Presbyterian Health Plan may recover its benefit payments from you.

ASSIGNMENT OF BENEFITS

Your benefits under the Plan generally cannot be transferred or assigned in any way, except as required under a Qualified Medical Child Support Order (QMCSO). A qualified child support order is a court order that may be granted in the case of a divorce.

FRAUDULENT APPLICATION OR CLAIM

If you knowingly make a false statement on your enrollment Application or file a false claim, such Application or claim will be revoked retroactively back to the date of the Application or claim. If a claim is paid by Presbyterian Health Plan and it is later determined that the claim should not have been paid due to a fraudulent Application or claim, the Member shall be responsible for full reimbursement of the claim amount to Presbyterian Health Plan.

GRIEVANCE PROCEDURES

Overview

Many Grievances or problems can be handled informally by calling Presbyterian Health Plan (PHP) at (505) 923-7752 or toll-free at 1-670-670-0600

PHP has established written procedures for reviewing and resolving your Grievances and concerns. There are two different procedures, depending on the type of Grievance.

If your Grievance concerns a decision by PHP to deny, reduce or terminate a requested healthcare service because it is either not a Covered Benefit or it is not Medically Necessary, the Grievance will be subject to the adverse determination Grievance review procedure. See "Adverse Determination Review Procedures" in this Section.

Administrative Grievances: If your Grievance concerns any other action or inaction by PHP concerning any other aspect of PHP's health benefits plan, other than the request for healthcare services, including but not limited to, administrative practices of the healthcare insurer that affect the availability or delivery of healthcare services, claims payment, handling or reimbursement for healthcare services and terminations of Coverage, then the Grievance will be subject to the administrative Grievance review procedure. See "Administrative Grievance Procedures" in this Section.

Any Grievance may be submitted orally or in writing. If you make an oral Grievance, our Customer Service Center will assist you to complete the required forms. Please be advised that PHP shall not take any retaliatory action against you for filing a Complaint. You may request a copy and detailed written explanation of the Grievance procedures by calling PHP at (505) 923-7752 or toll-free at 1-866-670-0600 Members have 180 days from the date of the initial denial to file an Appeal with Presbyterian Insurance Company.

ADVERSE DETERMINATION REVIEW PROCEDURES

When you or your treating healthcare professional requests a healthcare service, Presbyterian Health Plan (PHP) shall initially determine whether the requested healthcare service is covered by your health benefits plan and is Medically Necessary within 24 hours where circumstances require expedited review and five working days for all other cases. If PHP's initial review results in the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the determination and of your right to request an internal review by PHP.

You may request an internal review orally or in writing by contacting:

Presbyterian Health Plan
Grievance Department
P.O. Box 27489
Albuquerque, NM 87125
(505) 923-7752 or toll-free at 1-866-670-0600
Fax (505) 923-5124
Email: info@phs.org

PHP's internal adverse determination Appeal review procedures require an initial review by a PHP medical director. The review must be completed within 72 hours when the circumstances require expedited review or within 20 working days for all other cases. If PHP's medical director decides to uphold the denial, reduction or termination of the requested healthcare service, then PHP will notify you of the medical director's decision by telephone and mail.

ADMINISTRATIVE GRIEVANCE PROCEDURES

If you are dissatisfied with a decision, action or inaction of Presbyterian Health Plan (PHP) regarding a matter that does not involve the denial, reduction or termination of a requested health service, then you have the right to request, orally or in writing, that PHP internally review the matter. First, a PHP representative will review the Grievance and provide you with a written decision within 15 working days from receipt of the Grievance.

CNM GRIEVANCE REVIEW PROCEDURES

If the grievant is not satisfied with Presbyterian Health Plan's decision under either category above, he/she may appeal the decision by filing a formal complaint to the Authority within 30 days of the day the Grievance decision was made. (Note: You may contact CNM at any time during the Grievance process.) Upon receipt of the appeal request, the Authority will review the case and respond to the parties involved within 30 days.

Central New Mexico Community College CNM
Director of Benefits
525 Buena Vista Drive SE
TM 104
Albuquerque New Mexico 87106
(505) 224-4600

EXTERNAL REVIEW BY SUPERINTENDENT OF INSURANCE

If you are dissatisfied with the results of the internal review by Presbyterian Health Plan (PHP), the medical panel, or the CNM, you may request an external review by the New Mexico Superintendent of Insurance by filing a written request within 120 working days for Adverse Determination review and within 20 working days for an Administrative Grievance review from the date you receive the Benefits Advisory Committee of PHP decision. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation commission, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689;
- Email to the Superintendent of Insurance, Attention: Managed Health Care Bureau at mhcb.grievance@state.nm.us; or
- Fax to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, at (505) 827-3833; or
- Online by completing the NM PRC, Division of Insurance Complaint Form available at www.phs.org-

RETALIATORY ACTION

In accordance with the Patient Protection Act, Presbyterian Health Plan cannot, and will not, take retaliatory action against you for filing a Grievance under this health benefits plan.

SECTION 6 – MEMBERS RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health plan. Above all, your relationship with your Provider/Practitioner is essential to good health. We encourage open communication between you and your Provider/Practitioner. Member rights and responsibilities regarding your health insurance can be found on the PHP/PIC website at www.phs.org/memberright or by calling the Presbyterian Customer Service Center at (505) 923-7752 or toll-free at 1-866-670-0600

GLOSSARY OF TERMS

ACCIDENTAL INJURY means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia, or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an Accidental Injury.

ACUPUNCTURE means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

ADMISSION means the period of time between the date a patient enters a Hospital or other facility as an Inpatient and the date he/she is discharged as an Inpatient. The date of Admission is the date of service for the hospitalization and all related services.

ALCOHOLISM means alcohol dependence or alcohol abuse meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

AMBULANCE SERVICE means a duly licensed transportation service, capable of providing Medically Necessary life support care in the event of a life-threatening situation.

AMBULATORY SURGICAL FACILITY means an appropriately licensed provider, with an organized staff of Physicians that meets all of the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not a facility used primarily as an office or clinic for the private practice of a Physician or other professional provider.

APPLICATION means the form that an employee is required to complete when enrolling for Presbyterian Health Plan coverage.

ATTENDING PHYSICIAN means the doctor who is responsible for the patient's Hospital treatment or who is charged with the patient's overall care and who is responsible for directing the treatment program. A consulting Physician is not the Attending Physician. A Physician employed by the Hospital is not ordinarily the Attending Physician.

AUTISM SPECTRUM DISORDER means a condition that meets the diagnostic criteria for the pervasive development disorders published in the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, including Autistic Disorder; Asperger's Disorder; Pervasive Development Disorder not otherwise specific; Rett's Disorder; and Childhood Disintegrative Disorder.

PRIOR AUTHORIZATION means the process whereby Presbyterian Health Plan or Presbyterian Health Plan's delegated provider contractor reviews and approves, in advance, the provision of certain Covered Services to Members before those services are rendered. If a required Prior Authorization is not obtained for services rendered by an Out-of-network Provider, the Member may be responsible for the resulting charges. Services rendered beyond the scope of the **Prior Authorization** may not be covered.

BIRTHING CENTER means an alternative birthing facility licensed under state law, with care primarily provided by a Certified Nurse Midwife.

CALENDAR YEAR means the period beginning January 1 and ending December 31 of the following year.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received during a benefit period that is the Member's responsibility.

CERTIFIED NURSE-MIDWIFE means a licensed Registered Nurse, certified by the American College of Nurse Midwives to administer Maternity care within the scope of the license.

CHIROPRACTOR means a person who is a Doctor of Chiropractic licensed by the appropriate governmental agency to practice chiropractic medicine.

CO-DEPENDENCY means behaviors learned by family Members or significant others in order to survive in an environment of great emotional pain and stress when a family Member is dependent upon the use of alcohol or drugs.

COINSURANCE means the amount, expressed as a percentage, of a covered health care expense that is partially paid by the Plan and partially the Member's responsibility to pay. The cost-sharing responsibility ends for most Covered Services in a particular Calendar Year when the Out-of-pocket Maximum has been reached.

CONGENITAL ANOMALY means any condition from birth significantly different from the common form, for example, a cleft palate or certain heart defects.

COPAY/COPAYMENT means the amount, expressed as a fixed-dollar figure, required to be paid by a Member in connection with Healthcare Services. Benefits payable by the Plan are reduced by the amount of the required Copayment for the covered service.

COSMETIC SURGERY means Surgery that is performed to reshape normal structures of the body in order to improve appearance and self-esteem.

COVERED SERVICES means services or supplies specified in this SPD, including any supplements, endorsements, addenda, or riders, for which benefits are provided, subject to the terms, conditions, limitations, and exclusions of this Summary Plan Description.

CUSTOM-FABRICATED ORTHOSIS means an Orthosis, which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may

involve the incorporation of some Prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially Prefabricated item.

CUSTODIAL CARE means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

DENTIST means a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMA) who is licensed to practice prevention, diagnosis, and treatment of diseases, Accidental Injuries, and malformation of the teeth, mouth, and jaws.

DEDUCTIBLE means the amount that must be paid for by you each Calendar Year toward Covered Services **before** health benefits for that Member will be paid by the Plan (except for those services requiring only a Copayment).

DEPENDENT means any Member of a covered employee's family who meets the requirements of Section 2 – Eligibility, Enrollment, Effective and Termination Dates, of this *Member Benefit Booklet* and is actually enrolled in the Plan.

DIAGNOSTIC SERVICES means procedures ordered by a Physician or other professional provider to determine a definite condition or disease.

DURABLE MEDICAL EQUIPMENT means equipment prescribed by a Physician that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the patient's further deterioration. This equipment is designed for repeated use, generally not useful in the absence of illness or Accidental Injury, and includes items such as oxygen or oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

EMERGENCY MEDICAL CONDITION means a medical condition which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to your health, if pregnant the health of you or your unborn child; 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part.

EXPERIMENTAL/INVESTIGATIONAL means any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and **not** Experimental or Investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;

- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational settings.

FAMILY MEDICAL COVERAGE means coverage for the employee, the employee's spouse, and/or the employee's Dependent children.

FREESTANDING DIALYSIS FACILITY means a provider primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home basis.

FREESTANDING HEALTH CARE FACILITIES are those that are stand alone and on its own and deliver many diagnostic and therapeutic services formerly provided only in hospitals.

GENETIC INBORN ERRORS OF METABOLISM (IEM) means a rare, inherited disorder that is present at birth, results in death or mental retardation if untreated, and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

- disorders of protein metabolism (i.e. amino acidopathies such as PKU, organic acidopathies, and urea cycle defects);
- disorders of carbohydrate metabolism (i.e. carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis); or
- disorders of fat metabolism.

GRIEVANCE means an oral or written complaint submitted by or on behalf of a covered person regarding the:

- availability, delivery or quality of Healthcare Services;
- administrative practices of the healthcare insurer that affect the availability, delivery or quality of Healthcare Services;
- claims payment, handling or reimbursement for Healthcare Services; or
- matters pertaining to any aspect of the health benefits Plan.

HEALTHCARE PROFESSIONAL means a Physician or other healthcare practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Healthcare Services consistent with state law.

HEALTHCARE SERVICES means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, and includes, to the extent offered by the health benefits plan, physical and Behavioral Health, including community-based Behavioral Health.

HOME HEALTH AGENCY means an appropriately licensed provider that both:

- Brings Skilled Nursing and other services on an intermittent, visiting basis into the Member's home in accordance with the licensing regulations for home health agencies in New Mexico or in the locality where the services are administered, and
- Is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the Attending Physician.

HOSPICE means a duly licensed program or facility providing care and support to Terminally Ill Patients and their families.

HOSPITAL means a duly licensed provider that is a short-term, acute, general Hospital that meets all of the following criteria:

- Is a duly licensed institution;
- For compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service by or under the supervision of Registered Nurses;
- Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa, or sanitarium; and
- Is not a place for rest, for the aged, for the treatment of mental illness, Alcoholism, drug abuse, or pulmonary tuberculosis, and ordinarily does not provide Hospice or rehabilitation care, and is not a residential treatment facility.

IDENTIFICATION CARD or **ID CARD** means the card issued to the covered employee enrolled under this Plan.

IMMUNOSUPPRESSIVE DRUGS (Inpatient only) means drugs used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include but are not limited to: (1) preventing transplant rejection; (2) supplementing chemotherapy; (3) treating certain diseases of the immune system (i.e. "auto-immune" diseases); (4) reducing inflammation; (5) relieving certain symptoms; and (6) other times when it may be helpful to suppress the human immune response.

INDEPENDENT CLINICAL LABORATORY means a laboratory that performs clinical procedures under the supervision of a Physician and that is not affiliated or associated with a Hospital, Physician, or Other Provider.

IN-NETWORK PROVIDER means Physicians, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have contracted with Presbyterian Health Plan as In-network Providers.

INPATIENT means a Member who has been admitted by a healthcare Provider/Practitioner to a Hospital for occupancy for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge, and which are covered as defined in this Plan. Admissions are considered Inpatient based on medical necessity as identified in the Presbyterian Health Plan designated level of care criteria, regardless of the length of time spent in the Hospital.

LICENSED ACUPUNCTURIST means an Acupuncture practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

LICENSED NAPRAPATHIC means a naprapathy practitioner who is licensed by the appropriate state authority. Certification alone does not meet the licensure requirement.

LICENSED MASSAGE THERAPIST means a person who is licensed by the appropriate state authority as a "Licensed Massage Therapist" or "LMT." Certification alone does not meet the licensure requirement.

LICENSED LAY MIDWIFE means a person licensed by the state in which services are rendered to provide Healthcare Services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

LICENSED PRACTICAL NURSE (LPN) means a nurse who has graduated from a formal, practical nursing education program and is licensed by the appropriate state authority.

MAINTENANCE THERAPY means treatment that does not significantly enhance or increase the patient's function or productivity.

MATERNITY means any condition that is pregnancy related. Maternity care includes prenatal and postnatal care, and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or cesarean section.

MEDICAID means Title XIX of the Social Security Act and all amendments thereto.

MEDICAL CARE means professional services administered by a Physician or another professional provider for the treatment of an illness or Accidental Injury.

MEDICALLY NECESSARY means a service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under the Plan, and is determined by Presbyterian Health Plan's medical director to meet all of the following conditions:

- it is medical in nature; and
- it is recommended by the treating Physician; and
- it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternative that are equally effective;
  - cost-effectiveness, when compared to the alternative services or supplies;
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the Member, the treating Physician, the Hospital, or any other healthcare provider.

MEDICARE means the program of health care for the aged, end-stage renal disease (ESRD) beneficiaries, and disabled, established by Title XVIII of the Social Security Act and all amendments thereto.

MEDICARE ALLOWABLE means the maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the provider as it may be reduced by the co-insurance, deductible or amount beyond the annual maximum.

MEDICARE SUPPLEMENTAL COVERAGE means healthcare coverage that provides supplemental benefits to Medicare coverage.

MEMBER means the eligible employee or Dependent that is enrolled under this Plan.

MEMBER BENEFIT BOOKLET means this booklet.

CNM is the Central New Mexico Community College.

OBSERVATION means those furnished by a Hospital and Provider/Practitioner on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible Admission to the Hospital as an Inpatient, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient Observation stay, it is on the Provider's/Practitioner's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Member must meet the Presbyterian Health Plan designed level of care criteria to be considered an inpatient admission. The length of time spent in the Hospital is not the sole factor determining observation versus Inpatient status.

OCCUPATIONAL THERAPIST means a person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction, caused by disease, trauma, Congenital Anomaly, or prior therapeutic process, with specific tasks or goals directed activities designed to improve functional performance of the patient.

ORTHOPEDIC APPLIANCES/ORTHOTIC DEVICE/ORTHOSIS means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician, which supports or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

OTHER PROVIDER means a person or facility other than a Hospital that is licensed in the state where services are rendered, to administer Covered Services. Other Providers include:

- An institution or entity only listed as:
  - Ambulance Provider
  - Ambulatory Surgical Facility
  - Birthing Center
  - Durable Medical Equipment Supplier
  - Freestanding Dialysis Facility
  - Home Health Agency
  - Hospice Agency
  - Independent Clinical Laboratory
  - Pharmacy
  - Rehabilitation Hospital
  - Urgent Care Facility

- A person or practitioner only listed as:
  - Certified Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - Chiropractor
  - Dentist
  - Licensed Acupuncturist
  - Licensed Practical Nurse
  - Occupational Therapist

- Physical Therapist
- Podiatrist
- Licensed Lay Midwife
- Registered Nurse
- Respiratory Therapist
- Speech Therapist

OUT-OF-NETWORK PROVIDER means a duly licensed healthcare provider, including a medical facility, which has no agreement with Presbyterian Health Plan for reimbursement of services to Members.

OUT-OF-POCKET MAXIMUM means a specified dollar amount of Covered Services received in a Calendar Year that is the Member's responsibility, which is determined by the benefit level for the services received. It **does not include** expenses in excess of negotiated fees, Medicare allowable Charges, prescription drug Copayments, non-covered expenses, and specifically excluded expenses and services. The Out-of network, Out-of-pocket expenses do **not** accrue toward the Out-of-pocket Maximum and vice versa.

OUTPATIENT means care received in a Hospital department, Ambulatory Surgical Facility, Urgent Care facility, or Physician's office where the patient leaves the same day.

PHYSICAL THERAPIST means a licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body. A Physical Therapist treats disease or Accidental Injury by physical and mechanical means.

PHYSICIAN means a duly licensed practitioner of the healing arts acting within the scope of his/her license.

PODIATRIST means a licensed Doctor of Podiatric Medicine (DPM). A Podiatrist treats conditions of the feet.

PRESBYTERIAN HEALTH PLAN, INC. means Presbyterian Health Plan, a corporation organized under the laws of the State of New Mexico.

PRESCRIPTION DRUGS means those drugs that, by Federal law, require a Physician's prescription for purchase.

PREFABRICATED Orthosis means an Orthosis, which is manufactured in quantity without a specific patient in mind. Prefabricated Orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted.) An Orthosis that is assembled from Prefabricated components is considered Prefabricated. Any Orthosis that does not meet the definition of a Custom-Fabricated Orthosis is considered Prefabricated.

PROSTHESIS, PROSTHETIC DEVICE means an externally attached or surgically implanted artificial substitute for an absent body part, for example, an artificial eye or limb.

PROVIDER means a duly licensed Hospital, Physician, or Other Provider performing within the scope of the appropriate licensure.

REGISTERED NURSE (RN) means a nurse who has graduated from a formal program of nursing and is licensed by appropriate state authority.

REHABILITATION HOSPITAL means an appropriately licensed facility that, for compensation from its patients, provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RESPIRATORY THERAPIST means a person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

SEMI-PRIVATE means a two or more bed Hospital room, Skilled Nursing Facility or other healthcare facility or program.

SKILLED NURSING CARE means services that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse or Registered Nurse.

SKILLED NURSING FACILITY means an institution that is licensed under state law to provide Skilled Nursing Care services.

SPECIAL CARE UNIT means a designated unit that has concentrated all facilities, equipment, and supportive devices for the provision of an intensive level of care for critically ill patients.

SPECIALIST means a Doctor of Medicine (MD) or Doctor of Osteopathy (DO). A Specialist is not a family practitioner, general practitioner, pediatrician, or internist and OBGYN

SPECIAL MEDICAL FOODS means nutritional substances in any form that are:

- formulated to be consumed or administered internally under the supervision of a Physician and prescribed by a Physician;
- specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- intended for the medical and nutritional management of Members with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- essential to optimize growth, health and metabolic homeostasis.

SPEECH THERAPIST means a speech pathologist certified by the American Speech and Hearing Association. A Speech Therapist assists patients in overcoming speech disorders.

SURGERY means the performance of generally accepted operative and cutting procedures, including:

- Specialized instrumentation, endoscopic examinations, and other invasive procedures;
- Correction of fractures and dislocations; and
- Usual and related preoperative and postoperative care.

TEFRA means Federal law regarding the working aged.

TERMINALLY ILL PATIENT means a Member with a life expectancy of six months or less as certified in writing by the Attending Physician.

TWO-PARTY COVERAGE means coverage for the employee and his/her spouse, or coverage for the employee and one Dependent child.

URGENT CARE means medically necessary healthcare services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

WELL CHILD CARE means routine pediatric care through the age of 72 months, and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

ACCEPTANCE PAGE

The Central New Mexico Community College agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the CNM PPO Medical Plan.

By: [Place Holder for Signature]

Date:

Notice of Nondiscrimination and Accessibility
Discrimination is Against the Law

Presbyterian Health Services (Presbyterian) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Presbyterian does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Presbyterian:

- provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at 505-923-5420, 855-592-7737, TTY 711.

If you believe that Presbyterian has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Presbyterian Privacy Officer and Civil Rights Coordinator, P.O. Box 27489, Albuquerque, NM, 87125, or call 866-977-3021. You can file a grievance in person, by mail, email, or the above phone number. If you need help filing a grievance, call 866-977-3021 and a customer representative will assist you.

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, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**