PRESBYTERIAN

Presbyterian Health Plan, Inc.

Summary Plan Description
and
Guide to Your
Preferred Exclusive Provider Organization (EPO)
and
Preferred Provider Organization (PPO)

Pharmacy Only Plan

County of Bernalillo

Offered by the County of Bernalillo
Administered by Presbyterian Health Plan

County of Bernalillo
EPO Pharmacy Only Plans
MPC 062266

07/01/2022

WELCOME

This benefit booklet describes the Pharmacy benefits offered through the County of Bernalillo.

This booklet is intended to provide you with an easy-to-understand explanation of the Pharmacy Only plan effective July 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.

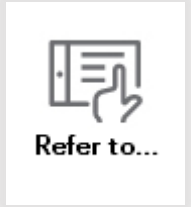
This booklet does not imply a contract of employment. The County of Bernalillo reserves the right to terminate, modify, or change this Plan or any provision of this Plan at any time.

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.

Medical coverage is administered by Blue Cross Blue Shield of New Mexico. Questions specific to Medical Coverage and Benefits can be made by contacting BCBSNM Customer Service at 1-800-432-0750.

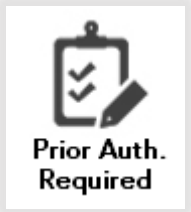
UNDERSTANDING THIS SUMMARY PLAN DESCRIPTION

We use visual symbols throughout this Summary Plan Description (SPD) to alert you to important requirements, restrictions and information. When one or more of the symbols is used, we will use bold print in the paragraph or section to point out the exact requirement, restriction, and information. These symbols are listed below:

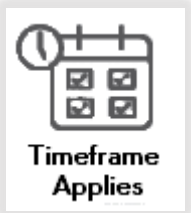


Refer To – This "Refer To" symbol will direct you to read related information in other sections of the SPD or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.

Exclusion – This "Exclusion" symbol will appear next to the description of certain Covered Benefits. The Exclusion symbol will alert you that there are some services that are excluded from the Covered Benefits and will not be paid. You should refer to the Exclusion Section when you see this symbol.



Prior Authorization Required – This "Prior Authorization" symbol will appear next to those Covered Benefits that require our Authorization (approval) in advance of those services. To receive full benefits, your In-network Provider must call us and obtain Authorization before you receive treatment. You must call us if you are seeking services Out-of-network.



Timeframe Requirement – This "Timeframe" symbol appears to remind you when you must act within a certain timeframe to comply with your Plan.

Important Information – This "Important Information" symbol appears when there are special instructions or important information about your Covered Benefits or your Plan that requires special attention. An example of Important Information would be if there are no Covered Benefits when you receive care Out-of-network.

Call Presbyterian Customer Service Center – This "Call PCSC" symbol appears whenever we refer to our Presbyterian Pharmacy Service Team to remind you to call us for information.

In addition, some important terms used throughout this SPD and the *Summary of Benefits and Coverage* will be capitalized. These terms are defined in the Glossary of Terms Section.

INTRODUCTION

The County of Bernalillo provides group healthcare coverage through the Exclusive Provider Organization (EPO) Pharmacy Only Plan (Plan) administered by Presbyterian Health Plan, Inc. (PHP).

This booklet is your *Summary Plan Description (SPD*). It describes the benefits and limitations of the Plan.

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

- In-network Pharmacies have contractual agreements with PHP that allow lower out-of-pocket expenses and additional benefits for covered persons.

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 our Presbyterian Pharmacy Service Team, Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146**, or **1-888-867-1071**. **(TTY: 711)**. 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 the Plan.

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HOW THE PLAN WORKS

PLAN YEAR OUT-OF-POCKET MAXIMUM

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

The Plan Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits*.

For Single Coverage, the Out-of-pocket Maximum requirement is fulfilled when one Member meets the Individual Out-of-pocket Maximum listed in the *Summary of Benefits and Coverage*.

For Double or Family Coverage, with two or more enrolled Members, the **entire** Family Out-of-pocket Maximum must be met before benefits will be paid at 100%. However, if one (family) Member reaches the Individual Out-of-pocket Maximum amount before the family has met the Family Out-of-pocket Maximum, benefits will be paid at 100% for that Member who has met the Individual Out-of-pocket Maximum. The Family and Individual Out-of-pocket Maximums amounts are listed in the *Summary of Benefits and Coverage*.

HEALTHCARE 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 how much the insurance company will be charged for the tests.
- Be very cautious about giving information about your insurance coverage over the telephone.

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

ELIGIBILITY, ENROLLMENT, EFFECTIVE AND TERMINATION DATES

EMPLOYEE ELIGIBILITY

An eligible employee includes anyone hired as classified, probationary, term or hourly, if the employee works an average of at least 20 hours per week over the course of a pay period and whose length of employment, when hired, is for at least six months. Independent contractors are not eligible under the County's benefit plan.

Dual coverage is not allowed. If both an employee and their spouse/domestic partner are eligible employees, they *cannot* enroll each other as a spouse/domestic partner, nor can they both cover their children. If both eligible employees seek to enroll their spouse/domestic partner and/or Dependents, the enrollment will be rejected, and forms returned for proper election.

DEPENDENT ELIGIBILITY

Dual coverage is not allowed. An eligible Dependent cannot be covered by more than one employee participating in the Plan.

An eligible employee's Dependents are eligible to be covered under the Group Benefits Plan as follows:

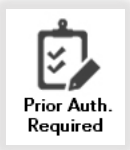
- An eligible employee's lawful spouse may be enrolled as a Dependent after presenting a marriage certificate or other documentation which establishes that the couple entered into a valid common-law marriage in another jurisdiction.
    - An eligible employee's domestic partner may be enrolled as a Dependent upon submission of executed Affidavits of Domestic Partnership. Please see Domestic Partner section for further information.
- Children of an eligible employee's domestic partner under the age of twenty-six (26) may be enrolled as Dependents upon submission of a birth certificate, legal adoption papers and/or guardianship order.
- An eligible employee's children and legal Dependents under the age of twenty-six (26) may be enrolled as Dependents upon submission of a birth certificate, legal adoption papers, and/or guardianship order.
- Disabled legal Dependents that are incapable of self-support are eligible for medical, dental and vision coverage beyond age twenty-six (26). Evidence of legal guardianship and disability is required upon enrollment.
- A court order directing that an employee and/or employee's Dependent provide insurance for someone else does not require the County of Bernalillo to grant eligibility. Individual coverage may need to be purchased separately. **NOTE:** A "Power of Attorney" is not considered a court order to establish State Plan eligibility or otherwise extend coverage under the County of Bernalillo.

- If an employee's spouse has stepchildren from a previous marriage, and neither the employee nor spouse has adopted them or obtained legal guardianship, the stepchildren are not eligible for coverage.

According to Federal IRS Guidelines, premiums for domestic partners/child(ren) **cannot** be taken on a pre-tax basis.

To receive benefits under this Plan, you and your eligible Dependents must reside within the Plan's authorized Service Area. However, please review the following as it relates to Dependents who live both in and/or out of the authorized Service Area, who are also eligible for benefits.

- If the Dependent attends school in any Presbyterian Health Plan Service Area, services may either be received through the Primary Care Provider or at the Student Health Center.
- If the Dependent is eligible for coverage under this Plan as the result of a court order and the Dependent does not live within the Service Area:
  - You or the covered Dependent is responsible for obtaining any required **Prior Authorization**s from the Plan. If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan.



It is your responsibility to notify your agency group representative, who will then notify the Claim Administrator, of any change in your coverage status, including a name or address change.

The Claim Administrator reserves the right to verify your eligibility for coverage by requesting proof from you or your agency group representative that a valid employer-employee relationship exists and that you otherwise meet all applicable eligibility requirements.

ENROLLING FOR COVERAGE

You must complete and return an enrollment form within 31 days of your eligibility date. If you don't elect coverage within 31 days of your eligibility date and later want coverage, you must wait until the next open enrollment period to receive coverage – unless you have a qualified change in status or you are eligible as a result of a special enrollment event. If you have a qualified change in status or special enrollment event, you will be able to elect coverage within 31 days of the change.

Once you complete an enrollment form, your elections remain in effect through the Plan Year – from July 1 to June 30. Each year you will have an opportunity to change your group health Plan June 1 to June 30. Each year you will have an opportunity to change your group health Plan elections. The change is effective the following July 1. You and your Dependents will be automatically re-enrolled in the Plan each year unless you complete a new enrollment form changing your election during the enrollment period.

HOW TO ENROLL DEPENDENTS

You may apply for coverage of your eligible Dependents, which may mean changing from Employee only coverage to Coverage that Includes Dependent or Family Coverage. Each additional Dependent added to your coverage must be enrolled within 31 days of becoming eligible for the Plan.

Newly adopted children are effective on the date of placement and must be enrolled within 31 days of that date.

WHEN COVERAGE STARTS

If you enroll on or before the day you become eligible, your coverage becomes effective the day you are eligible. If you enroll within 31 days of becoming eligible, your coverage becomes effective on the day that you enroll or the first day of the following pay period. Coverage begins on the first day of the current pay period if forms are completed and required documents are brought to New Employee Orientation or submitted to the Benefits Office by the end of the first week. If forms are submitted after that but within the 31-day enrollment period, coverage begins on the first day of the pay period following the submission of completed forms and verification of the Dependent eligibility.

Contact your agency group representative for further details.

The Plan pays for Covered Services that a Member receives on or after the effective date of coverage.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

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 Dependents in this Plan. You must request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption. If you have any questions about this law, contact your agency group representative.

CHANGING YOUR COVERAGE

Once you elect coverage, you generally cannot change your elections until the following enrollment period. However, there are certain circumstances when you may be eligible to change coverage earlier. You must request the change in coverage within 31 days of the event causing the change. Any change must be consistent with the reason the change was permitted. Situations governed by HIPAA special enrollment rules:

- You, your spouse, or your Dependent children become eligible for Consolidated Omnibus Reconciliation Act (COBRA) continuation coverage.
- Judgment, decree or order that requires accident or group health coverage for your child.
- You, your spouse or Dependent children become entitled to Medicare or Medicaid. (You may cancel coverage for the individual who becomes eligible for Medicare or Medicaid coverage.)
- Change in status event, but only when the change causes you or your Dependent to gain or lose eligibility for coverage. The change must correspond with the gain or loss of coverage.

It is your responsibility to notify your agency group representative, who will then notify the Claim Administrator, of any change in your coverage status, including a name or address change.

FAMILY STATUS OR EMPLOYMENT STATUS CHANGES (QUALIFYING EVENTS)

You may make certain changes to your benefit elections within **31 days** of a change in family/employment status. Evidence of a change in family/employment status must be provided to your agency group representative in order to change your benefit elections. Any change in coverage must correspond with the gain or loss of coverage and will become effective on the first pay period following the date the new benefit elections are made. The only exceptions would be birth and adoption, where the additional coverage would take place immediately upon enrollment. The following family/employment status changes are recognized by the County of Bernalillo:

- Marriage or divorce;
- Legal Separation;
- Birth or adoption of a child;
- Death of a spouse or Dependent child;
- A change in your spouse's employment (loss of job, or a new job that provides healthcare coverage; however, annual enrollment for a spouse's plan is not a family status change);
- A change in legal responsibility for a child;
- The end of the month in which the Dependent child turns 26;
- Qualification or disqualification of a domestic partner; and
- Change in employment status (regular part-time to regular full-time or vice versa).

SPECIAL ENROLLMENT/NOTICE OF EMPLOYEE RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you are declining enrollment for yourself or your Dependents (including your spouse and eligible children) because of other group health insurance coverage, you may in the future be able to

enroll yourself or your Dependents in the Plan. You must request enrollment within 31 days after you or an eligible Dependent loses coverage under another group health plan either because:

- Eligibility ends;
- COBRA benefits are exhausted;
- You return to work after serving active military/reserve duty; or
- Employer contributions end

In addition, if you have a new Dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

An otherwise eligible employee and Dependent(s) who did not apply for coverage when initially eligible because of other group coverage at another place of employment, but who later lost their coverage due to a change in employment status, may apply within 31 days if the loss of coverage is due to loss of employment/change in job status, death of a spouse, or divorce from a spouse. This provision also applies to employees who return to work after serving active military/reserve duty.

ID CARD

Your Plan ID Card identifies the cardholder and your EPO coverage. Carry it with you.

When you present your card to In-network Pharmacies, they know that you receive special benefits – they will file claims for you. You are responsible for any Copayments, Coinsurance or expenses for non-Covered Services.

Your Member identification number and your group number are on your ID Card. Each of your Dependents will also receive an ID Card. The reverse side of your ID Card provides the pharmacy billing information for Presbyterian Health Plan and some important telephone numbers for your use while using the Plan. It is important that you always show each individual's own ID Card when obtaining care.

If you want additional cards or need to replace a lost card, contact a Presbyterian Pharmacy Service Team representative.

This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits.

TERMINATION

If you are an employee of the County of Bernalillo covered by this Pharmacy Only Plan, you have the right to choose this continuation of coverage if you lose your group health coverage due to a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

If you are the spouse of an employee covered by the Group healthcare Plan, you have the right to choose continuation of coverage for yourself if you lose group health coverage under the Group's Plan for any of the following reasons:

- The death of your spouse;
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare benefits.

A Dependent child of an employee covered by the Group's healthcare Plan has the right to continuation of coverage if group healthcare coverage under the Group's Plan is lost for any of the following reasons:

- The death of the parent employee;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer;
- Parent's divorce or legal separation;
- The Dependent ceases to be a Dependent child under the Plan; or
- The parent employee becomes entitled to Medicare.

Under this law, the employee or a family Member has the responsibility to inform the Plan Administrator (your agency group representative) of a divorce, legal separation or a child losing Dependent status under the Group Plan.

A COBRA qualifying event also occurs upon an employee's death, termination of employment or any reduction in hours that disqualifies the person for group coverage, or Medicare entitlement (in the case of terminating employees only).

Should one of the above events occur, the Plan Administrator will in turn notify you (within 14 days of receipt of notification) that you have the right to choose continuation of coverage. Under this law, you have at least 60 days from the date you would lose coverage due to one of these events to inform the Plan administrator that you want continuation of coverage.

If you do not choose continuation of coverage, your group health coverage will end.

If you choose continuation of coverage, your employer is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This law requires that you be given the opportunity to maintain continuation of coverage for up to 36 months, unless you lost group healthcare coverage due to a termination of employment or reduction in hours, in which case the required continuation coverage period is 18 months, unless you have been determined to be disabled under the Social Security Act, in which case the required continuation coverage period is 29 months. However, this law also provides that your continuation coverage may be cut short for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees;
- The premium for your continuation coverage is not paid on time;

- You become covered under another group health plan because of employment or re-employment (whether or not you are an employee of that employer), unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have;
- You are a widow or were divorced from a covered employee and subsequently remarry and are covered under your new spouse's health plan unless the new plan contains an exclusion or limitation relating to any pre-existing condition you may have;
- You become entitled to Medicare benefits (coverage may continue for your spouse); or
- It is determined that you are no longer disabled (shortens the extended period).

You do not have to show that you are insurable to choose continuation coverage. However, under this law, you may have to pay 102% (150% in the case of the 19th through 29th month for a disabled person) of the full premium for your continuation coverage.

For more information regarding COBRA, contact your agency group representative.

COBRA AND THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

A leave that qualifies as a Family and Medical Leave under the FMLA does not make you eligible for COBRA coverage. However, whether or not you lose coverage because of nonpayment of premiums during a Family and Medical Leave, you may be eligible for COBRA on the last day of the leave, which is the earliest of the following:

- The date you unequivocally inform your agency group representative that you are not returning at the end of the leave;
- The date your leave ends, assuming you do not return; or
- The date the FMLA entitlement ends.

For purposes of a Family and Medical Leave, you will be eligible for COBRA only if:

- You or your Dependent is covered by the Plan on the day before the date the leave begins (or becomes covered during the leave);
- You do not return to employment at the end of the leave; and
- You or your Dependent loses coverage under the Plan before the end of what would be the maximum COBRA continuation period.

COVERED SERVICES

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

If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any Prescription Drug, 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 the Filing Claims Section.

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 to 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 are covered 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.

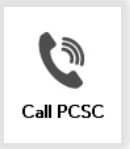
DIABETES SERVICES

This Benefit has one or more exclusions as specified in the Exclusions section.

Covered Benefits are provided if you have insulin Dependent (Type I) diabetes, non-insulin Dependent (Type 2) diabetes and elevated blood glucose levels induced by pregnancy (gestational diabetes). We will guarantee Coverage for Prescription Drug/Medications, insulin or supplies that meet the United States Food and Drug Administration (FDA) approval, and are the medically accepted standards for diabetes treatment

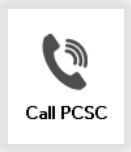
Diabetes supplies.

The following supplies are covered when prescribed by your Provider and when obtained through Presbyterian Pharmacy network. Please contact our Presbyterian Pharmacy Service Team, Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146** or **1-888-867-1071. (TTY: 711)**. You may also visit our website at **www.phs.org** for further information.



- Insulin pumps when Medically Necessary- Refer to your Formulary for Preferred Insulin Pumps.
- Specialized monitors/meters for the legally blind

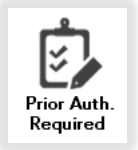
The following equipment, supplies, and services are Covered when prescribed by your Practitioner/Provider and when obtained through the designated Pharmacy Network*. Please contact our Presbyterian Service Team, Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146** or **1-888-867-1071** or TTY: 711. Visit the Formulary listing for coverage details at



http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf.

- Preferred insulin pumps - Some services require **Prior Authorization.** Refer to your *Formulary* for Preferred insulin pumps.
- Specialized monitors/meters for the legally blind.
- Preferred prescriptive diabetic oral agents for controlling blood sugar levels –refer to your *Formulary* for Preferred agents.
- Glucagon emergency kits.
- Preferred insulin – refer to your *Formulary* for Preferred insulin.
- Syringes.
- Injection aids, including those adaptable to meet the needs of the legally blind.
- Preferred blood glucose monitors/meters – refer to your *Formulary* for Preferred monitors.
- Preferred test strips for blood glucose monitors – Refer to your *Formulary* for Preferred test strips.
- Preferred lancets and lancet devices.
- Urine ketone strips
- Preferred continuous glucose monitoring (CGM)* including (system, sensor, transmitter). Some services require **Prior Authorization**. Refer to the Prior Authorization Section for **Prior Authorization** requirement. Refer to your *Formulary* for Preferred CGM.
- Visual reading

*Diabetes supplies covered through the Medical benefit are provided by BCBSNM. Call BCBCNM Customer Service at 1-800- 432-0750 for additional information.



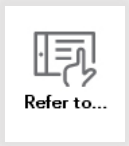
If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required.

PRESCRIPTION DRUG MEDICATIONS

This Benefit has one or more exclusions as specified in the Exclusions Section.

Covered Prescription Drugs/Medications

Prescription Drug/Medication Benefit (Outpatient)



Outpatient Prescription Drugs are a Covered Benefit when prescribed by your Provider for up to a 90-day supply. Refer to your Formulary for information on the approved Prescription Drugs and any limits or requirements. For a complete list of these drugs, please see the PHP Commercial Large Group Plan formulary list at:

http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf.

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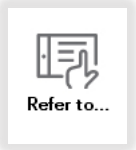
Affordable Care Act (ACA)

We will provide Coverage for preventive medications and products as defined by the Affordable Care Act (ACA) if you receive these services from In-network Providers, without cost sharing regardless of sex assigned at birth, gender identity or gender of the individual.

Preventive medications are used for the management and prevention of complications from conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke.

Drug or Category	Criteria
Aspirin	Helps to reduce the risk of heart attacks
Anti-cholesterol agents	Helps to reduce the risk of heart disease
Oral Fluoride	Helps to prevent cavities Age 6 months to 5 years
Folic Acid	Helps to prevent major birth defects
Primary breast cancer	Helps to prevent breast cancer
Smoking Cessation	Helps to reduce the risk of cancer and heart disease
Colonoscopy Prep	Bowel prep Minimum 50 years of age
Women's Contraceptives	FDA approved contraceptive methods **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000007352**
HIV for Prep	Pre-exposure pro

Preventive medications will be listed as $0 Copay per PPACA. For preventive medications (including over-the-counter medications) or products to be covered, you'll need to get a prescription from your doctor and a pharmacy claim will need to be submitted. Present your ID card to the dispensing pharmacy for processing and billing information.



Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at:

https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000007352

You can call our Presbyterian Pharmacy Service Team, Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146** or **1-888-867-1071**. **(TTY: 711)**.

What is a Formulary?

A drug formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of Providers, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications. Presbyterian Health Plan administers a closed formulary, which means that non-formulary drugs are not routinely reimbursed by the plan. Medical exception policies provide access to non-formulary medication when Medical Necessity is established.

The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. For the most up-to-date formulary drug information visit **http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf**

Presbyterian Health Plan will provide material that contains in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility and **Prior Authorization** requirements, within a reasonable time after enrollment and at subsequent periodic times as appropriate.

Can the Formulary Change During the Year?

The formulary can change throughout the year. Some reasons why they can change include:

- New drugs are approved
- Existing drugs are removed from the market
- Prescription Drugs may become available over the counter (without a prescription)
- Brand-name drugs lose patent protection and generic versions become available
- New clinical guidelines

If we remove drugs from our formulary, add quantity limits, **Prior Authorization**, and/or step therapy restrictions on a drug; or move a drug to a higher cost-sharing tier, we must notify affected Members of the change at least **60 days** before the change becomes effective.

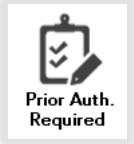
How is the Formulary Drug List Developed?

The medications and related products listed on a formulary are determined by a Pharmacy and Therapeutics (P&T) Committee or an equivalent entity. The Presbyterian Health Plan P&T Committee is made up of Primary Care and specialty Providers, clinical pharmacists and other professionals in the healthcare field.

The P&T Committee reviews and updates the formulary list each quarter (four times per year). Medications chosen for the formulary are selected based on their safety, effectiveness and overall value. A medication may not be added to the formulary if current drugs on the formulary are equally safe and effective and are less costly. Utilization management strategies such as quantity limits, step therapy and **Prior Authorization** criteria are reviewed and approved by the P&T committee.

Medication coverage criteria is updated and reviewed to reflect current standards of practice. The overall goal of the P&T Committee is to provide a formulary that gives Members access to safe, appropriate and cost-effective medications that will produce the desired goals of therapy at the most reasonable cost to the Member and the healthcare system.

What is a 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 healthcare 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, Provider participation, state and federal regulations, and our policies and procedures.

- Continuation of therapy using any drug is dependent upon its demonstrable efficacy.
- Note that the prior use of free prescription medications (i.e., samples, free goods, etc.) will not be considered in the evaluation of a Member's eligibility for medication coverage.

What is Step Therapy?

Step Therapy promotes the appropriate use of equally effective but lower-cost formulary drugs first. With this program, prior use of one or more "prerequisite" drugs is required before a step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drugs.

What are Quantity Limits?

Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your Provider and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian Health Plan uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following:

- **Maximum Daily Dose** limits quantities to a maximum number of dosage units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a single day. Limits are based on daily dosages shown to be safe and effective, and that are approved by the Food and Drug Administration (FDA).
- **Quantity Limits over time** limits quantities to number of units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time.

Behavioral Health Drugs at zero cost share
Formulary prescription drugs used for the treatment of mental illness, behavioral health, or substance use disorders when obtained from a behavioral health specialist maybe covered at no cost share. Coverage at no cost share is subject to applicable benefit plans. Refer to the formulary listing at **http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf** for additional coverage details.

Non-Extended Day Supply

Presbyterian has established protocols under the guidance of National Committee for Quality Assurance (NCQA) to ensure patients' safety for identified high-risk medications. Pursuant to this guidance, Presbyterian has limited the maximum allowed day supply down to 30 days at a time for medications that fall into this high-risk category. These drugs are found in the Commercial 4 Tier formulary as Non-Extended Day Supplies.

Medication Synchronization

Medication Synchronization allows Members to refill all their Prescriptions on the same day, eliminating the need for multiple trips to the Pharmacy each month. Prescriptions are filled for less than the normal prescribed day supply in order to align the refill date across multiple prescriptions, allowing all refills on the same day and time period.

Daily Cost Share

Daily cost share reduces the patient pay for the prescription that is less than the standard defined day supply. Exclusions may include drug products for acute therapy, unbreakable packages and controlled substances.

Insulin for Diabetes Cost Sharing Cap

The copay amount for a preferred formulary prescription insulin or a medically necessary alternative will be covered at an amount not to exceed a total of twenty-five dollars ($25.00) * per thirty-day supply.

Orally Administered Anti-Cancer Medications

This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same Prior Authorization requirements as intravenously administered injected cancer medications covered by the Plan. Orally administered medications cannot cost more than an intravenously injected equivalent. Intravenously injected medications cannot cost more than orally administered medications.

Drug Utilization Review and Drug use evaluation programs

Drug Utilization Review (DUR) is a review of patient data which is done to evaluate the effectiveness, safety and appropriateness of medication use. These DURs occur during claim adjudication and determine whether it is likely to cause harm based on interactions with other drugs or based on the Member's age, gender, allergies or other drugs on the Member's pharmacy profile. The DURs often alerts clinicians about prescribing and drug regimen problems and about patients who may be inappropriately taking medications that can produce an undesirable reaction or create other medical complications.

Generic Drugs

The Presbyterian Health Plan Commercial Large Group Plan Formulary covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand name drug. Generally, generic drugs cost less than brand name drugs.

Brand Name Drugs When a Generic Equivalent is Available

For each Prescription Drug/Medication purchased at our In-network Pharmacy, one applicable Preferred Generic, Preferred Brand or Non-Preferred Drug Cost-Sharing Amount will be required for a 30-day supply up to the maximum dosing recommended by the manufacturer/FDA. A generic equivalent will be dispensed if available.

If you or your healthcare Provider requests a brand name drug when a generic equivalent is available, you pay the difference in price between brand and generic, plus the applicable brand cost-sharing amount.

Benefit Limitations

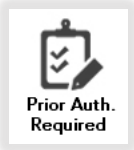
This benefit has one or more exclusions as specified in the Exclusions section.

You have the option to purchase up to a 90-day supply of Prescription Drugs/Medications. Under the 90-day at Retail Pharmacy benefit, Preferred Generic, Preferred Brand and Non-Preferred Drugs can be obtained from an In-network Pharmacy. If you choose the 90-days at retail option, you will be charged one copayment per 30-day supply up to a maximum of a 90-day supply.

You will be charged three applicable Copayments for up to a 90-day supply up to the maximum dosing recommended by the manufacturer/FDA.

Some medications may qualify for third-party copayment assistance programs which could lower your Out-of-pocket costs for those products. For any such medication where third-party copayment assistance is used (Discount Cards or Prescription Drug Savings Cards), the Member shall not receive credit toward their Out-of-pocket Maximum or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

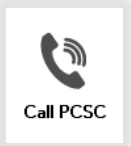
Self-Administered Specialty Pharmaceuticals



Self-Administered Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or a caregiver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life - threatening conditions. Most Specialty Pharmaceuticals require **Prior Authorization** and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than $600 for up to a 30-day supply.

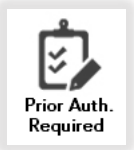
Specialty Pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill up to a 14-day supply to ensure patients can tolerate the new medication.

For a complete list of these drugs, please see the Specialty Pharmaceutical listing at **http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf**



You can call our Presbyterian Pharmacy Service Team, Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146** or **1-888-867-1071**. **(TTY: 711)**.

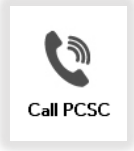
Office Administered Specialty Pharmaceuticals (Medical Drug)



A medical drug is any drug administered by a healthcare Provider and is typically given in the Member's home, the Provider's office, a freestanding (ambulatory) infusion suite, or an Outpatient facility. Medical drugs are managed by BCBSNM call 1-800-432-0750 for coverage information.

Mail Order Pharmacy

Members have a choice of obtaining certain Prescription Drugs/medications directly from a pharmacy or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and non-Preferred medications can be obtained through the Mail Order Service Pharmacy. You may purchase up to a 90-day supply up to the maximum dosing recommended by the manufacturer. Cost sharing Copayments apply at the applicable Tier Copayment and certain drugs may not be purchased by mail order, such as Self-Administered Specialty Pharmaceuticals.



You may obtain more information on the Mail Service Pharmacy by calling our Presbyterian Pharmacy Service Team Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146** or **1-888-867-1071 (TTY: 711)**.

Member Reimbursement

If a medical emergency occurs outside of our Service Area and you use an In-network Pharmacy, you will be responsible for payment of the appropriate Copayment. We have a large, comprehensive Pharmacy network; however, if you go to an Out-of-network Pharmacy and they are unable to process the claim at point of service, you may need to pay for the Prescription and submit a Direct Member Reimbursement Form. Reimbursement will be based on the negotiated rate between Presbyterian Health Plan and the dispensing Pharmacy minus any Copayment or Coinsurance that may apply. Members will not be liable to a Provider for any sums owed to the Provider by Presbyterian Health Plan.

The Pharmacy Specialist needs the following information to determine reimbursement amounts. Please submit a Direct Member Reimbursement Form and attach the itemized cash register receipt and the Prescription Drug detail (pharmacy pamphlet) along with the following information:

- Patient's name
- Name of the drug
- Quantity dispensed
- National Drug Code (NDC)
- Fill date
- Name of prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of payment

Direct Member Reimbursement Forms are available by calling our Presbyterian Pharmacy Service Team Monday through Friday from 8 a.m. to 5 p.m. at **(505) 923-8146** or **1-888-867-1071 (TTY: 711)**. Please follow the mailing instructions on the Member Reimbursement Form.

The Presbyterian Pharmacy Service Team is available **24 hours** a day to Providers, Pharmacies and Members to address pharmacy benefit questions. Please contact them at **(505) 623-8146** or **1-888-867-1071 (follow the voice prompts and select Pharmacy)**.

A registered professional nurse or Provider shall be immediately available by telephone **24 hours** a day, seven days a week, to render utilization management determinations for Providers.

Presbyterian Health Plan shall provide all Members and Providers with a toll-free telephone number by which to contact utilization management staff on at least a **five-day**, **40 hours** a week basis. All Members must have immediate telephone access **24 hours** a day, seven days a week, to their Primary Care Provider (PCP) or the PCP's authorized on-call back-up Provider. When these Providers are unavailable, a Registered Nurse or Provider on the utilization management staff must be available to respond to inquiries concerning Emergency or Urgent Care.

In the event Medically Necessary Covered Services are **not** reasonably available through participating healthcare Providers, Presbyterian Health Plan shall refer Members to a non-participating healthcare Provider and shall fully reimburse the non-participating healthcare Provider at the usual, customary and reasonable rate or at an agreed upon rate. Before Presbyterian Health Plan may deny such a referral to a non-participating Provider, the request must be reviewed by a Provider like the type of Provider to whom a referral is requested.

LIMITATIONS AND EXCLUSIONS

Please read this Section carefully. It identifies the limitations that apply to certain Covered Pharmacy Services. Medical Coverage and the Health Care Services are managed by BCBSNM, contact Customer Service at 1-800- 432-0750. The Limitations and Exclusion section provides details and information about supplies that are **Not Covered** under this Plan.

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's decision at any time. See "Grievance Procedures" in the Filing Claims Section.

LIMITATIONS

The following benefits have limits applied:

Preventive services are limited as listed on the *Summary of Benefits* and suggested frequency.

Weight loss treatment for obesity is subject to Medical Necessity**.**

EXCLUSIONS

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

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.

Before effective date benefits are not available for the 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.

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

Experimental or Investigational treatments 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.

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

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

Nonprescription and over the counter drugs are **not a covered benefit** 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.

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.

Prescription Drugs/Medications

- Prescription Drugs/Medications that require a Prior Authorization when Prior Authorization was not obtained are not Covered.
- New Prescription Drugs/Medications for which the determination of criteria for Coverage has not yet been established by our Pharmacy and Therapeutics Committee are not Covered.
- Prescription Drugs/Medications purchased outside the United States are not Covered.
- Prescription Drugs/Medications, medicines, treatments, procedures, or devices that we determine are Experimental or Investigational are not Covered.
- Prescription Drugs/Medications that have not been approved by the FDA are not Covered.
- Prescription Drugs/Medications prescribed for off-label or unproven indications are not Covered.
- Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective (LTE) DESI drugs are not Covered.

- Replacement Prescription Drugs/Medications resulting from loss, theft, or destruction are not Covered.
- Disposable medical supplies, except when provided in a Hospital or a Practitioner's/Provider's office or by a home health professional, are not Covered.
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are not Covered.
- Oral or injectable medications used to promote pregnancy are not Covered.
- Over-the-counter (OTC) medications and drugs are not Covered. Refer to our Formulary for a list of Covered Over-the-counter (OTC) medications as determined by our Pharmacy and Therapeutics Committee.
- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are not Covered.
- Prescription Drugs/Medications for the purpose of weight reduction or control, except for Medically Necessary treatment for morbid obesity, are not Covered.
- Prescription Drugs/Medications used for cosmetic purposes are not Covered.
- Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are not Covered.
    - Infant formula is not Covered under any circumstance
- Compounded Prescription Drugs/Medications are not Covered.
    - Bulk powders are not Covered.
    - Compounding Kits are not Covered
- Discount Cards or prescription Drug Savings Cards do not apply to Deductible or Out of Pocket Maximum.
- Brand name drugs dispensed when a generic equivalent is available will not count towards Deductible or Out of Pocket Maximums.
- Herbal or alternative medicine and holistic supplements are not Covered.
- Vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, or functional capacity examinations related to employment are not Covered
- Immunizations for the purpose of foreign travel, flight and or passports are not Covered.
- Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including "all-natural" pills, creams, lotions and gels are Not Covered.
- LDAA Local Delivery of Antimicrobial Agents used for Periodontal Procedures are Not Covered.

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

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

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.

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 for the Act.)

Online Resources for members already enrolled in the plan

- Check Prescription pricing and coverage
- Request and Manage Home Delivery
- Locate a participating retail pharmacy
- Obtain health information and much more

Helpful numbers you may need

Presbyterian Pharmacy Service Team Monday through Friday 8 a.m. thru 5 p.m. **505-923-8146** or **1-888-867-1071.**

- A Clinical Pharmacist is available for urgent/emergent concerns after hours and holidays
- 24/7) Language assistance – translation services are available for non-English speaking patients

FILING CLAIMS

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.

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 Presbyterian Pharmacy Service Team 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 Plan 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 a Member receives more than they should have when benefits are coordinated, the Member is 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 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 County of Bernalillo Plan 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 based on end-stage renal disease.

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. If 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 Pharmacy Service Team at **(505) 923-8146** or **1-888-867-1071.**

Presbyterian Health Plan (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 Health Care 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 its health benefits plan, other than the request for Health Care Services, including but not limited to, administrative practices of the healthcare insurer that affect the availability or delivery of Health Care Services, claims payment, handling or reimbursement for Health Care 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 Presbyterian Pharmacy Service Team 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 Presbyterian Pharmacy Service Team at **(505) 923-8146** or **1-888-867-1071**.

Members have 180 days from the date of the initial denial to file an Appeal with Presbyterian Health Plan.

ADVERSE DETERMINATION REVIEW PROCEDURES

When you or your treating healthcare Provider requests a healthcare service, Presbyterian Health Plan (PHP) shall initially determine whether the requested Health Care 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 Health Care 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:

Address: Presbyterian Health Plan
Grievance Department
P.O. Box 27489
Albuquerque, NM 87125
Phone: (505) 823-8146 or **1-888-867-1071**
Fax: (505) 923-6111
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 Health Care 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.

COUNTY OF BERNALILLO 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 the County of Bernalillo 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. If the appeal is

due to an emergency, a response will be given within 48 hours of receipt of such formal appeal request.

Address: County of Bernalillo
1 Civic Plaza, NW
Fourth Floor, Suite 4012
Albuquerque, NM 87102
(505) 468-1500
Fax: (505) 468-1527
Email: **hrbenefits@bernco.gov**

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 County of Bernalillo, 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 Office of 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 Office of Superintendent of Insurance, Attention: Managed Health Care Bureau at **mhcb.grievance@state.nm.us**; or
- Fax to the Office of Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, at **(505) 827-3833**
- Online by completing the NM PRC, Division of Insurance Complaint Form available at **http://www.nmprc.state.nm.us**

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.

GLOSSARY OF TERMS

COINSURANCE means the amount, expressed as a percentage, of a covered healthcare 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 Plan Year when the Out-of-pocket Maximum has been reached.

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.

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

COVERAGE THAT INCLUDES DEPENDENT means coverage for the employee and his/her spouse, or coverage for the employee and one Dependent child.

DEDUCTIBLE means the amount that must be paid by a Member each Plan 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 in the Eligibility, Enrollment, Effective and Termination Dates Section of this *Summary Plan Description* and is enrolled in the Plan.

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 his/her health and if pregnant, the health of the 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 in which 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.

GENETIC INBORN ERRORS OF METABOLISM (IEM) is 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., aminoacidopathies 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.

HEALTH CARE PROFESSIONAL means a Physician or other healthcare Provider, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

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.

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

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

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

MEDICAL CARE means professional services administered by a Provider or another professional Provider for the treatment of an illness or Accidental Injury. Medical Care is managed by BCBSNM, call Customer Service 1-800-432-0750.

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 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 alternatives that are equally effective;
- Cost-effectiveness, when compared to the alternatives 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 Provider, the Hospital or any other healthcare Provider.

MEDICARE means the program of healthcare 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 a fee schedule with a complete listing of fees used by Medicare to pay Hospitals or Providers/suppliers. This comprehensive listing of fee maximums is used to reimburse Providers for services rendered on a fee-for-service basis. CMS develops fee schedules for Providers, Ambulance Services, Clinical Laboratory Services and Durable Medical Equipment, Prosthetics, orthotics and supplies.

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.

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 Provider 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 Plan 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 Amounts, 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.

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

PLAN YEAR means the period beginning July 1 and ending June 30 of the following year.

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

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 Provider's prescription for purchase.

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.

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

SERVICE AREA means the entire state of New Mexico.

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

- Formulated to be consumed or administered internally under the supervision of a Provider and prescribed by a Provider;
- 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.

TEFRA means the Tax Equity and Fiscal Responsibility Act, a Federal law regarding the working aged.

ACCEPTANCE PAGE

The County of Bernalillo agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the County of Bernalillo EPO Medical Plan.

[By: _____] [Date:_____]