Presbyterian Health Plan, Inc.

Group Subscriber Agreement and Guide to Your Managed Care Plan

Presbyterian Health Plan, Inc.

Group Metal Benefit Plans
Engage HMO

*This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the New Mexico Health Insurance Exchange (**www.bewellnm.com**) if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.*

Underwritten by Presbyterian Health Plan

PHPGSAHMOHIXEngage_ON_2023

MPC042251
01.01.2023

PBHP-133267080

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

Address:
Presbyterian Health Plan
Attention: Presbyterian Customer Service Center
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone:
(505) 923-7521 or
1-855-923-7521
TTY 711

Prior Authorization

Address:
Presbyterian Health Plan
Attention: Health Services Department
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone:
(505) 923-8469 or
1-866-597-7835

Claims

Address:
Presbyterian Health Plan
Attention: Claims Department
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone:
(505) 923-7521 or
1-855-923-7521

Appeals and Grievances

Address:
Presbyterian Health Plan
Attention: Grievance Department
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone:
(505) 923-7521 or
1-855-923-7521
Fax:
(505) 923-6111

OR

Address:
Office of Superintendent of Insurance
Managed Healthcare Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689

Phone:
1-**833-415-0566**
Fax:
(505) 827-4734

Website

www.phs.org

PRE-EXPOSURE PROPHYLAXIS COVERAGE SUMMARY

ENDORSEMENT 1

THIS ENDORSEMENT CHANGES YOUR AGREEMENT WITH US

This endorsement summarizes HIV Pre-Exposure Prophylaxis (PrEP) medication coverage and essential PrEP services you are entitled to and replaces any part of your insurance agreement with us that provides less favorable coverage.

Pre-Exposure Prophylaxis (PrEP)

Your plan includes coverage for PrEP medication, as appropriate for you, and essential PrEP-related services without cost sharing, the same as any other preventive drug or service. This means that you do not have to make a copayment, pay coinsurance, satisfy a deductible or pay out-of-pocket for any part of the benefits and services listed in this summary if you receive them from an in-network provider.

You may be required to pay a copay, coinsurance, and/or a deductible if you receive PrEP medication or PrEP-related services from an out-of-network provider if the same benefit or service is available from an in-network provider.

What is Covered?

- At least one FDA-approved PrEP drug, with timely access to the PrEP drug that is medically appropriate for the enrollee, as needed
- HIV testing
- Hepatitis B and C testing
- Creatinine testing and calculated estimated creatine clearance or glomerular filtration rate
- Pregnancy testing for individuals with childbearing potential
- Sexually transmitted infection screening and counseling
- Adherence counseling
- Office visits associated with each preventive service listed above
- Quarterly testing for HIV and STIs, and annually for renal functions, required to maintain a PrEP prescription.

Grievance and Appeals Process

If you were charged cost sharing for coverage of PrEP medication or PrEP-related services on or after January 1st, 2021, please call our customer service line at 505-923-5678. If you would like to submit a grievance, the customer service representative can submit the request for you.

If you are denied coverage of a PrEP-related service(s), we will inform you in writing of the denial. Our notice to you will explain why we denied the coverage and will provide you with instructions for filing a grievance if you want to contest our decision. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP coverage denial by contacting customer service at:

Phone: (505) 923-5678 or at 1-800-356-2219
Address: Presbyterian Health Plan
Attn: Appeals and Grievance Department
P.O. Box 27489
Albuquerque, NM 87125-7489
Fax: (505) 923-6111
Email: gappeals@phs.org

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:

Phone: (505) 827-4601 or 1-833-415-0566
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
Fax: (505) 827-4734, Attn: MHCB
Email: mhcb.grievance@state.nm.us

Exception Process

If you have been denied coverage of a PrEP medication, we will inform you in writing of the denial. Our notice to you will provide you with instructions for filing an exception request if the medication that is most appropriate for your circumstances is not included in the drug formulary. You, your designee, prescribing physician or other prescriber can request a standard or expedited review of a PrEP medication coverage denial by contacting Customer Service at the number on the back of your ID card.

Standard Review

- We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within72 hours following receipt of your request.

Expedited Review

- If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a non-formulary drug, you can request an expedited review. We will review your request and issue a determination to you, your designee, prescribing physician or other prescriber, within 24 hours following receipt of your request.

If our initial determination is overturned, we will provide coverage for the PrEP medication or PrEP related service that is medically appropriate for you for the duration of the treatment.

For more information or assistance with your complaint, grievance or an exception request, you may contact the Managed Health Care Bureau (MHCB) of the Office of Superintendent of Insurance at:

Telephone: 1-833-415-0566
Office of Superintendent of Insurance-MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
E-mail: mhcb.grievance@state.nm.us

This endorsement is retroactive back to the effective date of your coverage with us, or January 1, 2022, whichever comes first. These items replace and supersede any conflicting provision of your insurance contract and summary of benefits and coverage. All other requirements of the policy not in conflict with this endorsement still apply.

Table of Contents

Welcome 13

Welcome to Presbyterian Health Plan! 13

Our Agreement with You 13

Understanding This Agreement 14

Customer Assistance 15

Member Rights and Responsibilities 17

This Section explains your rights and responsibilities under this Agreement and how you can participate on our Consumer Advisory Board.

Member Rights 17

Additional Member Rights and Responsibilities 18

Consumer Advisory Board 20

How the Plan Works 21

This section explains how to find Practitioners/Providers who are in our Network (In-network), get Healthcare Services both In-network and Out-of-network, requirements you must follow when getting care and how to receive Covered Benefits under this Agreement.

Provider Directory 22

Obtaining Healthcare 22

How to Obtain a PCP 22

Women's Healthcare Provider/Practitioner 22

Specialist Care 23

Obtaining Care after Normal Provider Office Hours 23

In-Network Practitioners/Providers 24

Out-of-network (outside of the 5-county area) Practitioners/Providers 24

Out-Of-Network Care And Bills 26

If you pay an Out-of-network Provider more than we determine you owe: 27
Restrictions on Services Received Outside of the PHP Service Area 27
National Health Care Practitioner/Provider Network 28
Cost-sharing – Your Out-of-pocket Costs 28
Annual Contract Year Deductible 28
Coinsurance 29
Annual Out-of-pocket Maximum 29
Office Visit Copayment 30
Utilization Management and Quality 30
Technology Assessment Committee 30
Transition of Care 31
Advance Directives 31

Prior Authorization 32

This Section explains what Covered Healthcare Services require Prior Authorization before you receive these services and how to obtain Prior Authorization.

What is Prior Authorization? 32

Prior Authorization Is Required 32

Prior Authorization when In-network 33

Prior Authorization when Out-of-network (outside of the 5-county area) 33

Services That Require Prior Authorization In- or Out-of-network (outside of the 5-county area) 34

Authorizing Inpatient Hospital Admission following an Emergency 36

Prescription drug Prior Authorization protocols 36

Prior Authorization and Your Coverage 36

Prior Authorization Decisions – Non-Emergency 36

Prior Authorization Decision – Expedited (Accelerated) 37

Prior Authorization Review – Initial Adverse Determination 37

Prior Authorization.....37

Benefits 40

This Health Care Benefit Plan offers Coverage for a wide range of Healthcare Service. This Section gives you the details about your benefits, Prior Authorization and other requirements, **Limitations and Exclusions**.

Specifically Covered 40

Medical Necessity 40

Care Coordination and Case Management.....41

PresRN 41

Health Management Programs.....41

Covered Benefits.....43

Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services 43

Ambulance Services..... 45

Bariatric Surgery..... 47

Clinical Trials..... 47

Certified Hospice Care..... 49

Clinical Preventive Health Services..... 50

Complementary Therapies 54

COVID-19..... 55

Dental Services (Limited)..... 55

Diabetes Services..... 56

Diagnostic and Imaging Services (tests performed to determine if you have a medical problem or to determine the status of any existing medical conditions) 58

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids 59

Hearing Aids..... 61

Electroconvulsive Therapy (ECT)..... 61

Employee Assistance Program 61

Family, Infant and Toddler (FIT) Program 61
Genetic Inborn Errors of Metabolism Disorders (IEM) 62
Genetic/Genomic Testing 62
Habilitative Services 63
Heart Artery Calcification Scan 63
Home Health Care Services/Home Intravenous Services and Supplies 64
Hospital Services – Inpatient 65
Hyperbaric Oxygen Therapy 65
Infertility 65
Mental Health Services and Alcohol and Substance Use Disorder Services 66
No Cost Sharing For Behavioral Health Services 66
Nutritional Support and Supplements 67
Orthotics 68
Outpatient Medical Services 68
Positron Emissions Tomography (PET) Scans in an Outpatient Setting 69
Practitioner/Provider Services 69
Prescription Drugs/Medications 71
Benefit Limitations 79
Proton Beam Irradiation 81
Reconstructive Surgery 82
Rehabilitation and Therapy 82
Selected Surgical/Diagnostic Procedures 83
Skilled Nursing Facility Care 84
Smoking Cessation Counseling/Program 84
Telemedicine Services 85
Transplants 85
Women's Healthcare 87

General Limitations 91

This Section explains the general limitations that apply to your Covered Benefits and other Sections of this Agreement.

Benefit Limitations 91

Major Disasters 91

Prior Authorization.....91

Exclusions.....92

This Section lists services that are not Covered for certain Benefits in your Health Benefits Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be Excluded Services except as required by state or federal law.

Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services.....92

Ambulance Services.....92

Autopsies.....92

Before or After the Effective Date of Coverage 92

Clinical Trials.....92

Care for Military Service Connected Disabilities.....93

Certified Hospice Care Benefits 93

Charges in Excess of Medicare Allowable Unreasonable 94

Clothing or Other Protective Devices 94

Clinical Preventive Health Services.....94

Complementary Therapies 94

Cosmetic Surgery 95

Cosmetic Treatments, Devices, Orthotics, and Prescription Drugs/Medications 95

Costs for Extended Warranties and Premiums for Other Insurance Coverage 95

Dental Services.....95

Diabetes Services 96

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids 96

Experimental or Investigational drugs, Diagnostic Genetic Testing, Medicines, Treatments, Procedures, or Devices 97

Extracorporeal Shock Wave Therapy 98

Foot Care 98

Genetic Testing 98

Genetic Inborn Errors of Metabolism Coverage 99

Hair-loss (or baldness) 99

Home Health Care Services/Home Intravenous Services and Supplies 99

Hospital Services 99

Mental Health and Alcohol and Substance Use Disorder 99

Nutritional Support and Supplements 100

Out-of-State Surcharges 100

Palliative Care 100

Practitioner/Provider Services 100

Prescription Drugs/Medications 101

Radiation 102

Reconstructive Surgery for Cosmetic Purposes 102

Rehabilitation and Therapy 103

Services for Which You or Your Dependent are Eligible under Any Governmental Program 103

Services Requiring Prior Authorization When Out-of-network (outside of the 5-county area)....103

Sexual Dysfunction Treatment....104

Skilled Nursing Facility Care....104

Smoking Cessation Services....104

Thermography....104

Transplant Services....104

Treatment While Incarcerated....104

War....104

Women's Healthcare....105

Work-related Illnesses or Injuries....105

Claims....106

Your Healthcare Benefits are paid according to the conditions outlined in the Section. If you paid Practitioners/Providers for services, this Section also outlines the process you should follow if you need to be reimbursed.

Notice of Claim....106

Claim Forms....106

In-network Practitioners/Providers....106

Out-of-network (outside of the 5-county area) Practitioners/Providers....107

Procedure for Reimbursement....107

Services Received Outside the United States....108

Claim Fraud....108

Effects of Other Coverage....109

This Section explains how we will coordinate benefits hsould you have medical coverage through another group Health Benefits Plan.

Coordination of Benefits 109

Medicare 111

Medicaid 111

Subrogation (Recovering Healthcare Expenses from Others) 111

Summary of Health Insurance Grievance Procedures 113

This Section explains how to file a Complaint, Grievance and Appeal.

What types of decisions can be reviewed? 113

Review of an Adverse Determination 113

Review of an Administrative Decision 119

General Information 120

Records 122

Your medical records are important documents needed in order to administer your Health Benefits Plan. This Section explains how we ensure the confidentiality of these records and how these records are used to administer your plan.

Creation of Non-Medical Records 122

Accuracy of Information 122

Consent for Use and Disclosure of Medical Records 122

Professional Review 122

Confidentiality of Protected Health Information/Medical Records 123

Eligibility, Enrollment, Effective Dates, Termination and Continuation 129

The Section explains eligibility requirements for Subscribers and/or their Dependents, important effective dates, conditions for Termination of Coverage and continuing Coverage for Members who become ineligible for this Plan.

How You Can Enroll as a Member 129

Residence of a Dependent Child 131

Enrollment and Effective Dates 132

Full, Accurate and Complete Information 139

Change in Address, Family Status and Employment 140

Termination of Coverage 140

Continuation of Coverage of Your Group Plan 143

General Provisions 151

This Section explains important information and provisions not covered in other Sections of this Agreement.

Amendments (Group) 151

Assignment 151

Entire Contract 151

Execution of Contract - Application for Coverage 151

Federal and State Healthcare Reform 151

Fraud 152

Practitioner/Provider Activity 152

Member Activity 152

Governing Law 153

Identification Cards 153

Legal Actions 153

Misrepresentation of Information 153

Misstatements 153

Notice 154

Policies and Procedures.....154

Reinstatements 154

Right to Examine.....154

Waiver by Agents.....154

Workers' Compensation Insurance.....154

Glossary of Terms 156

This Section defines some of the important terms used in this Agreement. Terms defined in this Section will be capitalized throughout the Agreement.

Exhibit A – Statement of ERISA Rights 177

Welcome

Welcome to Presbyterian Health Plan!

Welcome and thank you for joining Presbyterian Health Plan. We are a Healthcare Insurer operated as a division of Presbyterian Healthcare Services, a locally owned New Mexico healthcare system. When we use the words "Presbyterian Health Plan," "PHP," "we," "us," and "our" in this document, we are referring to Presbyterian Health Plan. When we use the words "you" and "your," we are referring to each Member.

As part of Presbyterian Healthcare Services, the health plan represents an organization with over **100 years** of community services to New Mexicans. Our priority has been and will continue to be improving the health of individuals, families and communities. We are working to make sure that you receive quality care and service.

We are pleased to provide you with access to a comprehensive network of Physicians, Hospitals, and outpatient medical Providers, who provide services for your Covered Benefits. We provide utilization management and quality improvement oversight programs with our commitment to Member service. We work closely with you, your Covered Dependents and your healthcare Practitioners and Providers to provide a quality, affordable healthcare plan.

Our Agreement with You

This is your Group Subscriber Agreement (Agreement) and it is a legal document. This Agreement, along with the *Summary of Benefits and Coverage*, describes the Covered Healthcare Benefits and plan features that you and your eligible Dependents may receive when you enroll.

This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Information you will find in this Agreement includes:

- Your rights and responsibilities as a Member
- Covered Benefits available through this Plan
- How to access services from physicians, Practitioners, Providers, and Pharmacies
- Services that require **Prior Authorization**
- **Limitations and Exclusions** for certain Covered Benefits
- Coverage for your Dependents who are outside of the 5-county area
- A Glossary of Terms used in this Agreement
- What to do when you need assistance

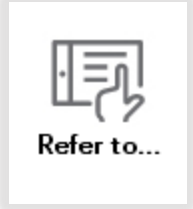
Throughout this Agreement, we ask you to refer to your *Summary of Benefits and Coverage*. The *Summary of Benefits and Coverage* is a chart that shows some specific Covered Benefits this Plan provides, the amount you may have to pay (Cost Sharing) and the Coverage **Limitations and Exclusions**.

Please take time to read this Agreement and *Summary of Benefits and Coverage*, including Benefits, **Limitations, and Exclusions**. This Agreement describes your benefits and your rights and responsibilities as our Member. It also gives details on how to choose or change your Primary Care Provider (PCP), what limits are placed on certain benefits, and what services are not Covered at all. Understanding how this Plan works can help you make the best use of your Covered Benefits.

You should keep this Agreement, your *Summary of Benefits and Coverage*, and any other attachments or Endorsements you may receive for future reference.

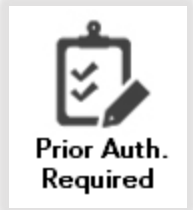
Understanding This Agreement

We use visual symbols throughout this Agreement 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 Agreement or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.

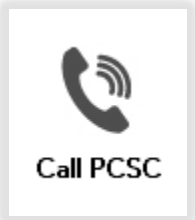
Exclusion – This "Exclusion" symbol will appear next to the description of certain Covered Benefits. The Exclusion symbol will alert you that there are some services that are excluded from the Covered Benefits and will not be paid. You should refer to the Exclusion Section when you see this symbol.



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 Practitioner/Provider must call us and obtain Authorization before you receive treatment. You must call us if you are seeking services Out-of-network (outside of the 5-county area). In the case of a Hospital in-patient admission following an Emergency Room visit, you or your physician should call as soon as possible.

Timeframe Requirement – This "Timeframe" symbol appears to remind you when you must take action within a certain timeframe to comply with your Plan. An example of a Timeframe Requirement is when you must enroll your newborn within **31 days** of birth.

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 how Dependent Students may receive Covered Benefits.



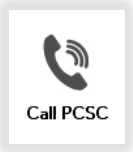
Call Presbyterian Customer Service Center – This "Call PCSC" symbol appears whenever we refer to our Presbyterian Customer Service Center or to remind you to call us for information.

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

Customer Assistance

Presbyterian Customer Service Center (PCSC)

If you have any questions about your Health Benefit Plan, please call our Presbyterian Customer Service Center. We have Spanish and Navajo speaking representatives and we offer translation services for more than 140 languages.



Our Presbyterian Customer Service Center representatives are available Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call the **TTY** line at **711**. You may visit our website for useful health information and services at **www.phs.org**.

Consumer Assistance Coordinator

If you need assistance completing any of our forms, if you have special needs, or if you need assistance in protecting your rights as a Member, please call our Consumer Assistance Coordinator at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call the **TTY 711** or visit our website at **www.phs.org**.

Written Correspondence

You may write to us about any question or concern at the following address:

Presbyterian Health Plan
Attention: Presbyterian Customer Service Center
P.O. Box 27489
Albuquerque, NM 87125-7489

Member Rights and Responsibilities

This Section explains your rights and responsibilities under this Agreement and how you can participate on our Consumer Advisory Board.

As a Member of Presbyterian Health Plan (PHP) you have specific rights and certain responsibilities.

In accordance with New Mexico Administrative Code, we implement written policies and procedures regarding the rights and responsibilities of Covered Persons. Your rights and responsibilities are important and are explained in this Section and on our website at **www.phs.org**.

Member Rights

The Group Subscriber Agreement (GSA) shall include a complete statement that a Member shall have the right to:

- Available and accessible services when medically necessary, **24 hour** per day, **7 days** per week for Urgent or Emergency Healthcare Services, and for other Healthcare Services as defined by the Agreement;
- A right to be treated with respect and recognition of their dignity and their right to privacy;
- Be provided with information concerning our policies and procedures regarding products, services, Providers, Appeals procedures and other information about Presbyterian Health Plan;
- To choose a Primary Care Practitioner within the limits of the Covered Benefits, plan network, and as provided by this rule, including the right to refuse care of specific Healthcare Professionals;
- Receive from the Covered Person's Physician(s) or Provider, in terms that the Covered Person understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options; of the Covered Person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the Covered Person's medical record;
- All the rights afforded by law, rule, or regulation as a patient in a licensed Healthcare Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Covered Person understands;
- Prompt notification, as required in this rule, of termination or changes in benefits, services or Practitioner/Provider network;
- File a Complaint or Appeal with us or the Superintendent and to receive an answer to those Complaints in accordance with existing law;

- Privacy of medical and financial records maintained by us and our Healthcare Providers, in accordance with existing law;
- Know upon request of any financial arrangements or provisions between Presbyterian Health Plan and our Practitioners/Providers which may restrict referral or treatment options or limit the services offered to Covered Persons;
- Adequate access to qualified Health Professionals for the treatment of Covered Benefits near where the Covered Person lives or works within our Service Area;
- To the extent available and applicable to us, to affordable healthcare, with limits on Out-of-pocket expenses, including the right to seek care from a non-participating or (Out-of-network (outside of the 5-county area) Provider in urgent or emergent situations only, and an explanation of a Covered Person's financial responsibility when services are provided by a non-participating (Out-of-network (outside of the 5-county area) Provider, or provided without required **Prior Authorization**;
- An approved example of the financial responsibility incurred by a Covered Person when going Out-of-network (outside of the 5-county area); inclusion of the entire "billing examples" provided by the Superintendent available on the Division's website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the Division's "billing examples" requires written approval by the Superintendent, in our Healthcare Benefit Plan that provides benefits for Out-of-network (outside of the 5-county area) Coverage;
- Detailed information about Coverage, Maximum Benefits, and Exclusions of specific conditions, ailments or disorders, including restricted Prescription benefits, and all requirements that a Covered Person must follow for **Prior Authorization** and Utilization Review;
- A complete explanation of why care is denied, an opportunity to Appeal the decision to our internal review, the right to a secondary Appeal, and the right to request the Superintendent's assistance.

Additional Member Rights and Responsibilities

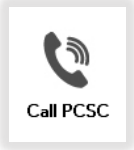
In addition to the rights and responsibilities afforded you by the state, we provide our Members with the following additional rights to:

- Receive information about our organization, our services and benefits, how to access Healthcare Services, our Practitioners and Providers, and your rights and responsibilities;
- Have a clear, private and candid discussion about appropriate or Medically Necessary treatment options for your medical condition regardless of cost or benefit Coverage;
- Participate with your Practitioner/Provider in making decisions about your healthcare;
- Refuse care, treatment, medication or a specific Practitioner/Provider, after the consequences of your decision have been explained in a language that you understand;
- Seek a second opinion for surgery from another In-network Practitioner/Provider when you need additional information regarding recommended treatment or requested care;
- Receive Healthcare Services in a non-discriminatory fashion. This means that you may not be denied Covered Services on the basis of race, color, sex, sexual preference, age,

handicap, cultural or educational background, religion or national origin, economic or health status or source of payment for care. If you have a disability you have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act;
- Make recommendations regarding our Members' rights and responsibilities policies;
- Make your wishes known through an Advance Directive regarding healthcare decisions, such as living wills or right-to-die directives, consistent with federal and state laws and regulations;
- Choose a surrogate decision maker to assist with care decisions. If you are unable to understand your medical care, to have the healthcare explanation provided to the next of kin, guardian, agent or surrogate if available, and recorded in your medical record including, where appropriate, a medical release that you signed authorizing release of medical information;

You and or your legal guardian/representative have the responsibility to:

- Provide, whenever possible, the information that we and your Practitioners/Providers need in order to provide services or care and to oversee the quality of those services or care;
- Follow the plans and instructions for care that you have agreed upon with your treating Practitioner/Provider. You may, for personal reasons, refuse to accept treatment recommended by Practitioners/Providers. Practitioners/Providers may regard such refusal as incompatible with continuing the Practitioner/Provider-patient relationship and as obstructing the provision of proper medical care;
- Understand your health problems and to participate in developing mutually agreed upon treatment plans and goals;
- Review your Group Subscriber Agreement (GSA) and if you have questions, contact our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**. You may visit our website at **www.phs.org** for clarification of Benefits, **Limitations, and Exclusions** outlined in this Subscriber Agreement.
  Translation/Interpretation services to understand your benefits are available, please call our Customer Service Center at the phone numbers listed above;

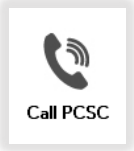


- Notify us within **31 days** of any changes of name, address, telephone number, marital status, eligible Dependents or newborns;
- Immediately notify us or any loss or theft of your PHP Identification Card;
- Refuse to allow any other person to use your PHP Identification Card;
- Advise a Practitioner/Provider of your Coverage with us at the time of service. You may be required to pay for services if you do not inform your Practitioner/Provider of our Coverage;
- Pay all required, pre-determined Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time services are rendered when amounts due are made clear at that time;

- Pay for all services obtained prior to the effective date of this Agreement and subsequent to its termination or cancellation
- Insure that all information you give to us in Applications for enrollment, questionnaires, forms or correspondence is true and complete;
- Be informed of the potential consequences of providing us with incorrect or incomplete information as described in this Agreement;
- Obtain **Prior Authorization** as described in the **Prior Authorization** Section;
- Pay any charges over Medicare Allowable.

Consumer Advisory Board

We have established a Consumer Advisory Board and we want your participation. This Board meets quarterly and provides Members' perspectives, as healthcare consumers, on the products and services that we offer. In addition, we share information with the Consumer Advisory Board on how well the health plan is performing. The information we receive is very valuable and helps us improve the health of individuals, families and communities. If you are interested in serving on our Consumer Advisory Board, please call our Presbyterian Customer Service Center, Monday through Friday, 7 a.m. to 6 p.m., at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**. You may also visit our website at **www.phs.org**.



How the Plan Works

This Section explains how your Health Benefit Plan works, how to access your Primary Care Practitioner to get Healthcare Services, requirements you must follow when getting care and how to receive Covered Benefits under this Agreement.

This plan is an "HMO" (Health Maintenance Organization). People who receive Healthcare Benefits through an HMO are sometimes called "Enrollees" or "Subscribers. We strive to work closely with Subscribers, their Covered Dependents, and their healthcare Practitioners/Providers to prevent illness and provide quality, cost-effective healthcare. Because of this close working relationship, we consider our Enrollees and Subscribers to be Members of our health plan.

PHP accepts premium and cost-sharing payments from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost-sharing): a Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act, an Indian tribe, tribal organization, or urban Indian organization, and a local, State, of Federal government program, including a grantee directed by a government program to make payments on its behalf.

We require that:

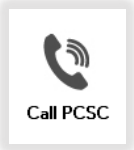
- You must physically live or work in the five counties of Central New Mexico which includes Bernalillo, Santa Fe, Sandoval, Valencia and Torrance county (our Service Area) unless you are a Dependent and meet all of the terms and conditions for such Coverage as outlined in the **Eligibility, Enrollment and Effective Dates, Termination and Continuation of Coverage Section**.
- All of your Healthcare Services are provided by provided by In-Network Contract Practitioner/Providers in our Service Area, except for Urgent and Emergency Healthcare Services situations. Please refer to the Benefits Section **Accidental Injury / Urgent Care / Emergency Healthcare Services / Observation / Trauma Services**.
- This product utilizes the Engage network for your in-network care. To review the Engage network of providers, please visit **https://www.phs.org/directory?network=ENGAGE**.
- You select a PCP from the Provider Directory to coordinate all of your care.
- You pay your pre-determined Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time you receive Covered Services. We will reimburse the Practitioner/Provider the balance for Covered Services based upon Total Allowable Charges (some services may not require a Cost Sharing Deductible, Coinsurance and/or Copayment). Refer to your *Summary of Benefits and Coverage* to find Covered Services subject to Cost Sharing amounts.

To receive care under our plan, you must select an In-network PCP to manage your healthcare needs. Your PCP will be able to meet most of these needs. A list of Practitioners/Providers who serve as In-network Primary Care Physicians may be found in the Provider Directory. PCPs include, but are not limited to, General Practitioners, Family Practice Physicians, Internists,

Pediatricians, and Obstetricians/Gynecologists (if applicable). As a Member of the health plan, you may choose as your PCP any doctor or Nurse Practitioner on that list.

If you do not designate a PCP on your enrollment form, we will suggest one for you.

Provider Directory



You will find our PCPs close to where you live and work across the State. The Provider Directory is available on our website at **https://www.phs.org/Pages/find-a-doctor.aspx**. If you need additional information about a provider, you may call our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**.

The Provider Directory is subject to change and you should always verify the Practitioner/Provider's network status by visiting our website at **https://www.phs.org/Pages/find-a-doctor.aspx**. Updates are made to the provider directory on a daily basis, so the online version is always the most current list. However, if you require a printed copy of the directory, you may request it by calling the Presbyterian Customer Service Center at the number above.

Obtaining Healthcare

How to Obtain a PCP

To receive care under this plan, you and all Covered Members of your family must select an In-network PCP to manage your healthcare needs. PCPs include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians and Obstetricians/Gynecologists (if applicable).

Establishing a relationship with your PCP is an important part of your healthcare benefits. Remember to contact or see your PCP before you seek medical treatment. Your PCP's role extends far beyond treating you when you are ill; he or she understands the importance of preventing illness and promoting healthier lifestyles. Your PCP expects to manage all of your health concerns and develop an understanding of your health history.

You may want to ask relatives or friends if they have a PCP they would recommend. A Physician may not be a PCP for him/herself or immediate family members. If you do not designate a PCP on your enrollment form, PHP will select one for you. You may change your PCP by contacting our Presbyterian Customer Service Center. The requested change will be effective the next business day after you call our Presbyterian Customer Service Center.

Women's Healthcare Provider/Practitioner

Any female Member age 13 or older may select an In-network Women's healthcare Practitioner/Provider listed as a PCP in our Provider Directory as her PCP. In addition, a female

Member age 13 or older who has not selected a Women's healthcare Practitioner/Provider as her PCP may consult with an In- network Women's healthcare Provider/Practitioner, without a referral from her PCP, for any gynecological service. No female Covered person shall be assessed a higher Cost-Sharing amount over and above the Cost-Sharing required of all Covered person to be seen by a primary care physician, for choosing a women's healthcare provider as her PCP

Specialist Care

As our Member, you must carefully follow all procedures and conditions for obtaining care from In-network specialists and/or Out-of-network (outside of the 5-county area) Practitioners/Providers. Out-of-network (outside of the 5-county area) Practitioners/Providers are Covered for emergency care only or if Medically Necessary care is not reasonably available in-network. Continuity of care may also allow out-of-network coverage for a temporary period. We no longer require a paper referral from your PCP for your visits to specialists. However, it is important to your healthcare that your PCP is included in the decisions about the specialists that you visit. Your PCP continues to be your partner for good health and is the best person to help you determine your needs for specialty care.

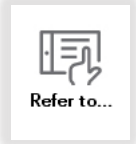
Effective communication about your medical history and treatment between your PCP and the specialists that provide care for you is very important so that the best decisions can be made about your medical care. We recommend that you contact your PCP's office regarding your desire to visit a specialist.

Please note that some specialists may require written referral even though we do not. Certain procedures require **Prior Authorization**. Your In-network Practitioner/Provider must obtain this **Prior Authorization** before providing these services to you. Please refer to the **Prior Authorization** Section of this Agreement.

Obtaining Care after Normal Provider Office Hours

Most Providers offer an after-hours answering service. For non-emergency situations, you should phone your PCP. If needed, you can find your PCP's phone number in the Provider Directory.

If Emergency Healthcare Services are needed, you should call 911, or seek treatment at an emergency room. If in need of Urgent Care, you may seek treatment at an Urgent Care Center that is available and open for business. Please note that some Urgent Care Centers are not open after 8 p.m. In such circumstances, it may be necessary to use an emergency room for care that is needed on an urgent basis. Please refer to the **Benefits Section, Accidental Injury / Urgent Care / Emergency Health Services / Observation /Trauma Services Benefits Section** of this Agreement for a detailed description of Coverage for Urgent and Emergency Healthcare Services.



In-Network Practitioners/Providers

In-network Practitioners/Providers, including PCPs, specialists, facilities and ancillary Healthcare Professionals, must be utilized, except in cases of an emergency. Members are responsible for paying the appropriate Cost Sharing (Deductible, Coinsurance and/or Copayments) directly to the In-network Practitioner/Provider at the time services are rendered when such amounts are clearly specified by the Practitioner/Provider. Hospital Inpatient Admission and some other Healthcare Services require our review and **Prior Authorization** before the services are provided. If you seek care from an In-network Practitioner/Provider, your In-network Practitioner/Provider will notify us and handle all aspects of your care. If that Practitioner/Provider fails to obtain a required **Prior Authorization** and the claim is denied, you will not be held accountable for those charges. Please refer to the **Prior Authorization** Section for complete details on **Prior Authorization**.

Generally, you will not have claims to file or papers to fill out in order for a claim to be paid. The Practitioner/Provider will bill us directly for the cost of services. Most services require Cost Sharing (Deductible, Coinsurance and/or Copayments) at the time of service. The amount of Cost Sharing for each service can be found in your Summary of Benefits and Coverage. In-network Practitioners and Providers cannot bill you for any additional costs over and above your Cost Sharing amounts.

When PHP terminates or suspends any contract with a participating provider, PHP/PIC will notify, in writing, affected covered persons who are current patients of or, where applicable, assigned to the provider, within 30 days. The notice to covered persons shall advise them of their right to continue receiving care from the provider as set forth in 13.10.23.13 NMAC. Current patients are covered persons who have a claim with Presbyterian Health Plan (PHP)/PIC related to the provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

PHP/PIC will assist such affected covered persons in locating and transferring to another similarly qualified provider. A covered person may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered person, if the covered person has not received comparable notice during this time from the provider.

We do not require our In-network Practitioners/Providers to comply with any specified numbers, targeted averages, or maximum duration of patient visits.

Out-of-network (outside of the 5-county area) Practitioners/Providers

Out-of-network (outside of the 5-county area) Practitioners/Providers are healthcare Practitioners/Providers, including non-medical facilities, who have not entered into an agreement with us to provide Healthcare Services to PHP Members on this plan.

Covered Healthcare Services obtained from an Out-of-network (outside of the 5-county area) Practitioner/Provider or outside the Service Area will not be Covered unless such services are not reasonably available from an In-network Practitioner/Provider or in cases of urgent or an emergency. You will not pay higher or additional Cost Sharing amounts under such circumstances. These provisions also apply to Telehealth services.

If you pay a non-participating Provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the non-participating Provider must refund to you within **45 calendar days** of receipt of payment from Presbyterian any amount paid in excess of the in-network cost-sharing amount. In accordance with the hearing procedures established pursuant to the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978], you may appeal Presbyterian's determination made regarding a surprise bill.

Services provided by an Out-of-network (outside of the 5-county area) Practitioner/Provider, except for urgent or Emergency services, require that your PCP request and obtain written approval (Authorization) from our Medical Director BEFORE services are rendered. Otherwise, you may be responsible for payment. Please refer to the **Prior Authorization** Section for more information on **Prior Authorization** requirements.

If the services of an Out-of-network (outside of the 5-county area) Practitioner/Provider are required, your In-network Practitioner/Provider must request and obtain **Prior Authorization** from our Medical Director BEFORE services are performed, otherwise, we may not Cover the services and you may be responsible for payment.

Before the Medical Director may deny a request for specialist services that are unavailable from an In-Network Practitioner/Provider, the request must be reviewed by a specialist similar to the type of specialist to whom the **Prior Authorization** is requested.

In determining whether a **Prior Authorization** to an Out-of-network (outside of the 5-county area) Practitioner/Provider is reasonable, we will consider the following circumstances:

- Availability – The In-network Practitioner/Provider is not reasonably available to see you in a timely fashion as dictated by the clinical situation.
- Competency – The In-network Practitioner/Provider does not have the necessary training or expertise required to render the service or treatment.
- Geography – The In-network Practitioner/Provider is not located within a reasonable distance from your residence. A "reasonable distance" is defined as travel where the distance to the service is no more than 60 miles.
- Continuity – If the requested Out-of-network (outside of the 5-county area) Practitioner/Provider has a well-established professional relationship with you and is providing ongoing treatment of a specific medical problem, you will be allowed to continue seeing that specialist for a minimum of **30 days** as needed to ensure continuity of care.
- Any **Prior Authorization** requested simply for your convenience **will not be considered to be reasonable**.

Services of an Out-of-network (outside of the 5-county area) Practitioner/Provider will not be Covered unless this **Prior Authorization** is obtained prior to receiving the services. **You may be liable for the charges** resulting from failure to obtain **Prior Authorization** for services provided by the Out-of-network (outside of the 5-county area) Practitioner/Provider.

Out-of-network (outside of the 5-county area) 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. We will only pay this claim if the service provided was Authorized by us or was due to an Urgent or Emergency Healthcare situation.

Out-Of-Network Care And Bills

If you receive care under any of the circumstances below from a Provider who is not in your network, these are your rights:

If you receive emergency care Out-of-network, including air ambulance service:

- You are only responsible for paying what you would owe for the same care from an In-network Provider or Facility.
- You do NOT need to get **Prior Authorization** for emergency services.
- Your care can continue until your condition has stabilized. If you require additional care after stabilization, call us at **1-866-597-7835** and we will help you receive that care from an In-network Provider.
- You cannot be balance billed.

If you receive care from an Out-of-network Provider at an In-network Facility, such as a Hospital that is in your plan, you are only responsible for paying what you would owe for the same care from an In-network Provider if:

- you did not consent to services from an Out-of-network Provider,
- you were not offered the service from an In-network Provider, or
- the service was not available from an In-network Provider - as determined by your Healthcare Provider and your health insurance company.

If you get a bill from an Out-of-network Provider under any of the above circumstances that you do not believe is owed:

- Call us first at **1-855-923-7521**. We will try to the resolve the issue with the provider on your behalf.
- If the problem has not been resolved by us, you can contact the New Mexico Office of Superintendent of Insurance at **www.osi.state.nm.us** or **(1-833-415-0566).**

To help stop improper Out-of-network bills, we will:

- Notify you if your Provider leaves our network and allow you transitional care with that Provider at the In-network benefit level for up to **90 days** depending on your condition and course of treatment.

- Verify the accuracy of our Provider directory information at least every **90 days**.
- Confirm whether a Provider is In-network if you contact us at **1-855-923-7521**. If our representative provides inaccurate information that you rely on in choosing a Provider, you will only be responsible for paying your In-network Cost Sharing amount for care received from that Provider.

You have the right to receive notice of the following before you receive Out-of-network care at an In-network Facility:

- A "good faith estimate" of the charges for Out-of-network care.
- At least **five days** to change your mind before you receive a scheduled Out-of-network service. If you choose to receive Out-of-network care you will be responsible for Out-of-network charges that we do not cover.
- A list of In-network Providers and the option to be referred to any such Provider who can provide necessary care.

If you pay an Out-of-network Provider more than we determine you owe:

- The Provider will owe you a refund within **45 days** of receipt of payment by us.
- If you do not receive a refund within that **45-day** period, the Provider will owe you the refund plus interest.
- You may contact the New Mexico Office of Superintendent of Insurance at **www.osi.state.nm.us** and **1- (1-833-415-0566)** for assistance or to appeal the provider's failure to provide a refund. You need to file the appeal within **180 days** of the **45-day** refund period expiration.

Services of an Out-of-network Practitioner/Provider will not be Covered unless this **Prior Authorization** is obtained prior to receiving the services unless in an urgent or emergent situation as defined by your benefits. **You may be liable for the charges** resulting from failure to obtain **Prior Authorization** for services provided by the Out-of-network Practitioner/Provider.

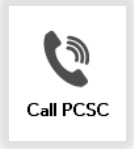
Out-of-network Practitioners/Providers may require you to pay them in full at the time of service. You may have to pay them and then file your claim for reimbursement with us. We will only pay this claim if the service provided was Authorized by us or was due to an Urgent or Emergency Healthcare situation.

Restrictions on Services Received Outside of the PHP Service Area

Emergency Healthcare Services and/or Urgent Care services outside of the State of the 5-county area will be Covered. For Emergency Healthcare Services and/or Urgent Care services received outside of the 5-county area, you may seek services from the nearest appropriate facility where Emergency Healthcare Services / Urgent Care services may be rendered. Cost-Sharing and benefits for an emergency healthcare service rendered by a non-participating provider shall be the same as if rendered by a participating provider.

National Health Care Practitioner/Provider Network

When receiving Urgent or Emergency Healthcare Services outside of the State of New Mexico you can help reduce the cost of such services by seeking care from one of our National Health Care Provider Network Practitioners/Providers. These cost savings can help minimize future premium increases.



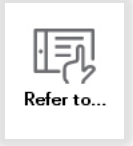
For additional information regarding National Health Care Practitioner/Providers please call our Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**.

Cost-sharing – Your Out-of-pocket Costs

Many Healthcare Services you receive from In-network and Out-of-network (outside of the 5-county area) Practitioners and Providers require some payment from you. We refer to these payments as Cost Sharing. These are your Out-of-pocket costs and may be Deductibles, Coinsurance and/or Copayment amounts. Cost-Sharing and benefits for an emergency healthcare service rendered by a non-participating provider shall be the same as if rendered by a participating provider. Cost-Sharing and benefit limitations for medically necessary, non-emergent healthcare services rendered by a non-participating provider at a participating facility where the covered person had no ability or opportunity to choose to receive the service from a participating provider where the covered person had no ability or opportunity to choose to receive the service from a participating provider or where no participating provider is available to render the service shall be the same as if the service was rendered by a participating provider. Cost-Sharing and benefit limitations for a medically necessary, non-emergent healthcare service where no participating provider is available to render the service shall be the same as if the service was rendered by a participating provider. It is recommended that you verify with Presbyterian Customer Service Center that services will be covered prior to receiving non-emergent healthcare services from a non-participating provider.

Annual Contract Year Deductible

Certain services are subject to an Annual Contract Year Deductible. The Annual Contract Year Deductible is the amount you and your Covered Dependents must pay for Covered Healthcare Services each Contract Year before we begin to pay Covered Benefits for that Member. The Annual Contract Year Deductible may not apply to all Healthcare Services. Refer to your *Summary of Benefits and Coverage* for the amount of your Annual Contract Year Deductible.



For Single coverage, the Annual Contract Year Deductible requirement is fulfilled when one Member meets the individual Deductible listed in the *Summary of Benefits and Coverage*.

For double or family coverage - The annual Contract Year deductible can be satisfied by any combination of the family members. No one member can contribute more than the stated member amount. Once a member meets their individual amount their annual Contract Year

deductible is considered met. The annual Contract Year Family and Individual Deductible amounts are listed in the *Summary of Benefits and Coverage*.

Coinsurance

Certain services are subject to a Coinsurance amount. Coinsurance is the percentage of Covered charges that you and your Covered Dependents must pay directly to the In-network Practitioner/Provider for Covered Services after the Annual Contract Year Deductible has been met. After you pay your Coinsurance amount, we will pay our percentage of the charges. Coinsurance is included in your Annual Out-of-pocket Maximum. The amount of your Coinsurance for each service can be found in your *Summary of Benefits and Coverage*.

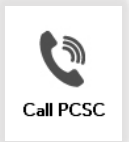
Annual Out-of-pocket Maximum

This Plan includes an Annual Out-of-pocket Maximum amount to help protect you and your Covered Dependents from high-cost catastrophic healthcare expenses. The Annual Out-of-pocket Maximum is the most you will pay in Cost Sharing in a Contract Year for certain Covered Services. After you have met your Annual Out-of-pocket Maximum in a Contract Year, we pay 100 percent (**100%**) of the cost for Covered Services, for the remainder of that Contract Year, up to the maximum benefit amount, if any. Refer to your *Summary of Benefits and Coverage* for the Plan Annual Out-of-pocket Maximum.

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 percent (**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 percent (**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*.

The Annual Out-of-pocket Maximum includes Deductible, Coinsurance and Copayments. **It does not include** non-covered charges including charges incurred after the benefit maximum has been reached. PHP pays 100 percent **(100%)** of Covered charges after the Out-of-pocket Maximum is met.



To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**.

Office Visit Copayment

If your Plan has an Office Visit Copayment, this is the amount of Cost Sharing you must pay each time you have an office visit with an In-network Practitioner/Provider. This Copayment is for the office visit only. All other services provided during the visit are subject to other Cost Sharing (Copayment, Deductible and Coinsurance). Refer to your *Summary of Benefits and Coverage* for all Cost Sharing Copayment, Deductible and Coinsurance amounts. Cost-Sharing and benefit limitations for a medically necessary, non-emergent healthcare service where no participating provider is available to render the service shall be the same as if the service was rendered by a participating provider. It is recommended that you verify with the Presbyterian Customer Service Center that services will be covered prior to receiving non-emergent healthcare services from a non-participating provider.

Utilization Management and Quality

We may review medical records, claims, and requests for Covered Services to establish that the services are/were Medically Necessary, delivered in the appropriate setting, consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of our professional medical consultants. Utilization management decisions are based only on appropriateness of care and service. We do not reward Practitioners or other Healthcare Professionals conducting Utilization Review for denying coverage or services and we do not offer incentives to encourage underutilization.

Members may seek a second opinion when questions arise as to the medical appropriateness of a diagnosis or the appropriateness of medical and/or surgical services. Members may seek the second opinion from any in-network provider. If you'd like to request a second opinion from an out-of-network provider, Presbyterian will assist you in making the arrangements. Typical cost-sharing will apply. If you'd like to request a second opinion from an out-of-network provider, please call the Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7521** or **1-855-923-7521** and tell them you'd like to request a second opinion from an out-of-network provider. PCSC staff will submit the request to Utilization Management on your behalf.

Technology Assessment Committee

We have a process to continuously evaluate evolving medical technologies, which include medical procedures, drugs and devices. In-network Practitioners from our Provider Network and the community along with other clinical staff are responsible for this process and are known as the Technology Assessment Committee.

The Technology Assessment Committee evaluates new technologies and/or new applications of existing technologies, determines the value of the new technology, and recommends whether the technology should be a specified Covered Benefit of your Plan. Factors to be considered include safety, comparison to existing drugs, procedures and technology, cost and effectiveness of the

new technology, and clinical skills and training of those proposing to provide the new technology.

Transition of Care

If we terminate or suspend any contract with an In-network Practitioner/Provider from which you are currently receiving care, we will notify you, in writing, within **30 days**. We will assist you in locating and transferring to another similarly qualified In-network Practitioner/Provider, if available, for continued In-network benefits. You may elect to continue to receive care from this Out-of-network (outside of the 5-county area) Practitioner/Provider; however, we will only reimburse for such services in accordance with applicable Out-of-network (outside of the 5-county area) benefit level, if any, and then subject to Medicare Allowable Charges except when you wish to continue an ongoing course of treatment with the provider for a transitional period. This period shall continue for a time that is sufficient to permit coordinated transition planning consistent with your condition and needs relating to the continuity of the case and will not be less than **30 days**. If you are in your third trimester of pregnancy at the time of the provider's disaffiliation, your transitional period will last through the delivery and will allow for postpartum care. These transitional periods with your provider will not be allowed if the provider's disaffiliation was for reasons related to medical competence or professional behavior. For transitional periods exceeding **30 days**, continued care will be provided only if the provider agrees to accept reimbursement from Presbyterian at the rates applicable prior to the start of the transitional period as payment in full. Additionally, the provider must also agree to adhere to Presbyterian's quality assurance requirements, to provide necessary medical information related to such care, and to follow Presbyterian's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization and treatment planning approved by Presbyterian.

Advance Directives

An Advance Directive is a legal document about your healthcare decisions. It is only used when you are unable to make your wishes known and includes information about the person you want to make healthcare decisions on your behalf as well as medical services you do and do not want. These are documents you complete in advance and can share with your provider or person who will speak on your behalf. Sharing your advance directives with your healthcare team helps make your wishes clear. You can create an Advance Directive at our website: **https://www.phs.org/tools-resources/patient/Pages/advance-directive.aspx**

Prior Authorization

This Section explains what Covered Healthcare Services require Prior Authorization before you receive these services and how to obtain Prior Authorization. This is not an exhaustive list. You can obtain further information through your PCP or, at our website at www.phs.org. If you have questions about a Prior Authorization submitted by your PCP/ Provider, please contact us Monday through Friday from 8 a.m. to 5 p.m. at (505) 923-8469 or 1-866-597-7835. Hearing impaired users may call TTY 711.

Before you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or other facility or before you receive certain Covered Healthcare Services and supplies, you must request and obtain approval, known as Authorization. All diabetes related services are provided in accordance with State law. For diabetes related services, please refer to the Diabetes Services Section. You may be responsible for the resulting charge ***except in cases of emergency***.

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Healthcare 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 Healthcare Service in consultation with your medical provider, 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.

A **Prior Authorization** will specify the length of time for which the Authorization is valid, which in no event shall be for more than 24 months. You may revoke an Authorization at any time.

A consumer or customer who is the subject of nonpublic personal information may revoke an authorization provided pursuant to this rule at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

Prior Authorization Is Required

Benefits for certain services and supplies are subject to **Prior Authorization** as specified in the **Prior Authorization** Section. Benefits may not be payable for services from Out-of-network (outside the 5-county area) Practitioners/Providers if you fail to obtain **Prior Authorization**.

If a required **Prior Authorization** is not obtained for services by Out-of-network (outside of the 5-county area) Practitioners/Providers, except for Emergency Care, the Member may be

responsible for the resulting charges. Services provided beyond the scope of the **Prior Authorization** may not be Covered.

Prior Authorization when In-network

When you seek specific Covered Services from In-network Practitioners/Providers, our In-network Practitioner/Provider is responsible for obtaining **Prior Authorization** from us before providing the Covered Services, except for Emergency Care. You will not be liable for charges resulting from the In-network Practitioner's/Provider's failure to obtain the required **Prior Authorization**.

Prior Authorization when Out-of-network (outside of the 5-county area)

Covered services obtained from an Out-of-network Practitioner/Provider or outside New Mexico will not be Covered unless such services are not reasonably available from an In-network Practitioner/Provider or in cases of an emergency.

If required medical services are not available from In-network Practitioners/Providers, the **PCP must request Prior Authorization and obtain written Authorization** from our Medical Director before you may receive Out-of-network services. **Services of an Out-of-network Practitioner/Provider may not be Covered** unless the visit is an urgent or emergent situation as defined by your benefits. this Authorization is obtained prior to receiving the services. You may be responsible for charges resulting from failure to obtain **Prior Authorization** for services provided by the Out-of-network Practitioner/Provider.

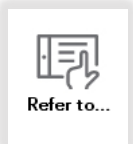
In determining whether a referral to an Out-of-network Practitioner/Provider is necessary, we, in consultation with your referring In-network Physician and/or PCP will consider the following circumstances:

- Availability – The In-network Practitioner/Provider is not reasonably available to see you in a timely fashion as dictated by the clinical situation.
- Competency – The In-network Practitioner/Provider does not have the necessary training or expertise required to render the service or treatment.
- Geography – The In-network Practitioner/Provider is not located within a reasonable distance from the patient's residence. A "reasonable distance" is defined as travel where the distance to the service is no more than 60 miles.
- Continuity – If the requested Out-of-network Practitioner/Provider has a well-established professional relationship with you and is providing ongoing treatment of a specific medical problem, you will be allowed to continue seeing that specialist for a minimum of **30 days** as needed to ensure continuity of care.
- Any **Prior Authorization** requested simply for your convenience will not be considered to be reasonable.

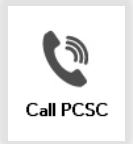
Services That Require Prior Authorization In- or Out-of-network (outside of the 5-county area)

Prior Authorization is required for Inpatient admissions, and all services related to the inpatient admission before you receive these services In-network or Out-of-network (outside of the 5-county area) from any Practitioner/Provider, Healthcare Facility or other Healthcare Professional. Our network of Practitioners/Providers will obtain **Prior Authorization** for you when you receive care In-network. You are responsible for obtaining **Prior Authorization** before you receive care Out-of- network, except for urgent or emergent situation as defined by your benefits. Presbyterian 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.

If you want to know more about **Prior Authorization**, please call our Presbyterian Customer Service Center, as soon as possible before services are provided, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521.** Hearing impaired users may call **TTY 711**



The following services and supplies require **Prior Authorization** In-network and Out-of-network (outside of the 5-county area). Refer to the **Benefits Section** for detailed information about these services.



Note: Due to the ever-changing nature of healthcare services, updates are made to the list from time-to-time throughout the year. For access to the most current list, you may contact our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**.

A complete and current list of the services subject to Prior Authorization can be found here: **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000002930**.

- Acute Medical Detoxification
- All Hospital admissions, Inpatient non-emergent
- Applied Behavior Analysis
- Bariatric Services and Surgery for the treatment of obesity
- Clinical Trials (Investigational/Experimental)
- Certified Hospice Care
- Computed Axial Tomography (CAT) scans in an outpatient setting
- Durable Medical Equipment
- Electroconvulsive Therapy (ECT)
- Epidural Injections for Back Pain
- Foot Orthotics

- Genetic/Genomic Testing
- Home Health Care Services/Home Health Intravenous Drugs
- Hyperbaric Oxygen
- Injectable Drugs, (includes Specialty Medications and Medical Drugs)
- Magnetic Resonance Imaging (MRI) in an outpatient setting
- Mental Health services - Inpatient, Partial Hospitalization and select outpatient services
- Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems
- Newborn Delivery and Hospital Obstetrical services
- Non-emergency care when traveling outside the U.S.
- Nutritional Supplements
- Observation Services greater than **24 hours**
- Organ transplants/Transplant Services
- Orthotics
- Positron Emission Tomography (PET) scans in an outpatient setting
- Prescription Drugs/Medications
- Prosthetic Devices
- Proton Beam Irradiation
- Reconstructive and potentially cosmetic procedures
- Selected Surgical/Diagnostic procedures
    - Blepharoplasty/Brow Ptosis Surgery
    - Breast Reconstruction following Mastectomy
    - Breast reduction for gynecomastia
    - Cholecystectomy by Laparoscopy
    - Endoscopy Nasal/Sinus balloon dilation
    - Gender Confirmational Surgery
    - Hysterectomy
    - Lumbar/Cervical Spine Surgery
    - Meniscus Implant and Allograft/Meniscus Transplant
    - Panniculectomy
    - Rhinoplasty
    - Tonsillectomy
    - Total Ankle Replacement
    - Total Hip Replacement
    - Total Knee Replacement
- Skilled Nursing Facility care
- Special Inpatient services for - example, private room and board and/or special duty nursing
- Special Medical Foods
- Substance Use Disorder services, Inpatient
- Transcranial Magnetic Stimulation
- Virtual Colonoscopy
- Wireless Capsule Endoscopy

Authorizing Inpatient Hospital Admission following an Emergency

You do not need to get **Prior Authorization** when you receive Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital following your Emergency Healthcare Services, your Practitioner/Provider or you should contact us as soon as possible.

Prescription drug Prior Authorization protocols

After January 1, 2014, a health care plan shall accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act as sufficient to request prior authorization for prescription drug benefits.
No later than twenty-four months after the adoption of national standards for electronic prior authorization, a health insurer shall exchange prior authorization requests with providers who have e-prescribing capability.
If a health care plan fails to use or accept the uniform prior authorization form or fails to respond within three business days upon receipt of a uniform prior authorization form, the prior authorization request shall be deemed to have been granted.
As used in this section, "health care plan" means a nonprofit corporation authorized by the superintendent to enter into contracts with subscribers and to make health care expense payments but does not include:

- a person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;
- a physician or a physician group to which a health care plan has delegated financial risk for prescription drugs and that does not use a prior authorization process for prescription drugs; or
- a health care plan or its affiliated providers, if the health care plan owns and operates its pharmacies and does not use a prior authorization process.

Prior Authorization and Your Coverage

- Eligibility and benefits are based on the date you received the services, not the date you received **Prior Authorization**.
- If you lose Coverage under this plan, services received after Coverage ends will not be Covered, even if we provided **Prior Authorization**.

Prior Authorization Decisions – Non-Emergency

We will evaluate non-emergent **Prior Authorization** requests and advise you and your Practitioner/Provider of our decision within **7 working days** after receiving all needed information.

Prior Authorization Decision – Expedited (Accelerated)

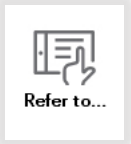
If your medical condition requires that we make a **Prior Authorization** decision quickly, we will notify you and your Practitioner/Provider of an expedited decision, within **24 hours** of our receipt of the written or verbal request for an expedited decision.

Prior Authorization Review – Initial Adverse Determination

If we do not approve the **Prior Authorization** request (Adverse Determination) we will notify you and your Practitioner/Provider by telephone (or as required by your medical situation) within **24 hours** of making our decision.

We will also notify you and your Practitioner/Provider of the Adverse Determination by written or electronic communication sent within **1 working day** of a telephone notice. Our notice will include:

- Reasons for a Medical Necessity denial including why the requested healthcare service is not Medically Necessary.
- The reason for a denial based on lack of coverage and a reference to all healthcare plan provisions on which the denial is based and a clear and complete explanation of why the Healthcare Service is not Covered.
- An explanation of how you may request our internal review of our Adverse Determination including any forms that must be used and completed.



Please see the **Complaints, Grievances and Appeals Section** for information regarding how to request an internal review of any Adverse Determinations that we make.

Prior Authorization

Prior Authorization *Requirement*

Certain types of care require ***Prior Authorization*** *by us.*

This means that you or your Provider must ask us to approve the care before you receive it.

A complete and current list of the services subject to **Prior Authorization** can be found here: **http://pel.phs.org/cs/groups/public/documents/communication/pel_00957159.pdf**.

The prescription drugs that are subject to a **Prior Authorization** requirement can be found at h**ttps://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**

We may decline payment for unauthorized care. If your Provider is In-network, and you did not agree to receive unauthorized care, your Provider cannot bill you for the care. If you received unauthorized care from a Provider who is not In-network you may be fully responsible for the resulting bills.

*We do not require **Prior Authorization** for:*

- Emergency services
- Contraception services that are not subject to any Cost-Sharing
- Obstetrical or gynecological ultrasound

However, we require authorization for continued in-patient care if you are admitted to a Hospital for Emergency treatment, but your condition is stabilized. You or your Provider must notify us as soon as possible from when you begin receiving Emergency in-patient treatment, and within **24 hours** after the Emergency ends and your condition stabilizes.

***Prior Authorization** Process*

Your In-network Provider is responsible for knowing what care requires **Prior Authorization**, and for submitting a **Prior Authorization** request to us.

We will give any Provider access to all necessary forms and instructions for making the request. An Out-of-network Provider is not required to submit a **Prior Authorization** request for you. If you visit one of these Providers, and that Provider will not submit a **Prior Authorization** request, you may submit a **Prior Authorization** request on your own behalf, or on behalf of a Dependent. We will help you obtain required documents and show you the guidelines that apply to the request. However, because your Provider should be able to gather required information and submit it sooner, we encourage you to have your Provider request **Prior Authorization** whenever possible.

***Prior Authorization** Review Timelines*

If we do not deny a complete **Prior Authorization** request within these time frames the request is automatically approved:

- **Urgent Care or Prescription Drugs –** If you require urgent medical care, behavioral health care or a prescription drug, we will resolve the request within **24 hours.**
- **Non-Urgent Medicine –** if you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your Provider:
    - Uses the **Prior Authorization** request form approved by the New Mexico Office of Superintendent of Insurance;
    - Requests an exception from an established step therapy process; or
    - Requests to prescribe a drug that we do not usually cover.
- **Other Requests –** We will resolve all other requests within seven business days.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your Provider might have concerning required information or any aspect of the request submission process. If we require additional

information to evaluate a request, we will request it from your Provider. Your Provider will have at least **four hours** to provide requested information in connection with an urgent **Prior Authorization** request, and at least two calendar days for any other type of request.

Why We Review

Our review of a **Prior Authorization** request will determine if the proposed care involves a covered service, is Medically Necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning Medical Necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional. **Prior Authorization** does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

If you received care without a required **Prior Authorization**, we may allow your Provider to request authorization retrospectively. Our utilization management team will assist your Provider in the submission of a retrospective authorization request. However, we do not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request **Prior Authorization.**

Behavioral Health Care

Requests for behavioral health care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions.

Authorization Denial

We will inform you in writing if we deny a prior or retroactive-authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process is included in this document. Please refer to the Table of Contents. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

*Record of **Prior Authorization***

A record of each **Prior Authorization** request and its associated documentation will be kept on file by Presbyterian in accordance state and federal law.

Benefits

This Healthcare Benefit Plan offers Coverage for a wide range of Healthcare Services. This Section gives you the details about your benefits, and other requirements, Limitations and Exclusions.

Specifically Covered

This Healthcare Benefit Plan helps pay for healthcare expenses that are Medically Necessary and Specifically Covered in this Agreement. Specifically Covered means only those Healthcare Benefits that are expressly listed and described in the **Benefits Section** of the Agreement. In addition, you should refer to the **Exclusions Section** that lists services that are not Covered under your Healthcare Benefit Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be **excluded, except for Clinical Preventive Health Services and except as required by state or federal law**.

There are no annual or lifetime limits on the dollar value of essential health benefits, as defined under the Affordable Care Act. Presbyterian Health Plan will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different form the one to which such health services are ordinarily or exclusively available.

We determine whether a Healthcare Service or supply is a specifically Covered Benefit. The fact that a Practitioner/Provider has prescribed, ordered, recommended, or approved a Healthcare Service or supply does not guarantee that it is a Covered Benefit even if it is not listed as an **Exclusion**.

Specifically, Covered Benefits are subject to the **Limitations, Exclusions, Prior Authorization** and other provisions of this Agreement.

Medical Necessity

This Healthcare Benefit Plan helps pay for healthcare expenses that are Medically Necessary and specifically Covered in this Agreement. Clinical Preventive Health Services do not have to be "Medically Necessary".

Medical Necessity or Medically Necessary means Healthcare Services determined by a Practitioner/Provider, in consultation with Presbyterian Health Plan (PHP), to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines we developed consistent with such federal, national, and professional practice

guidelines, for the diagnosis or direct care and treatment of a physical, behavioral or mental health condition, illness, injury, or disease.

Experimental or Investigational drugs, medicines, treatments, procedures, or devices are not Covered. This does not include Clinical Trials. Please refer to Clinical Trials in the Benefit Section of this Agreement.

Care Coordination and Case Management

Case Coordination and Case Management are provided by our Care Coordination department which is staffed with registered nurses, social workers, health educators, behavioral health specialists and non-licensed care coordinators that coordinate Covered and non-Covered Healthcare Services for you when you have ongoing or complex diagnoses.

The role of the care coordinator/case manager is to support and educate you and other Members, so that you are able to make informed healthcare decisions. Our ongoing communication and visits to you and to other Members who may have a chronic illness can trigger prompt intervention and help in the prevention of avoidable episodes of illness. We are committed to the personal service that care management provides to you when you are in need.

When you are in the Hospital, our coordinators/case managers work with the Hospital, their discharge planners and your Practitioners to make sure you get the appropriate level of care and to coordinate your care after you leave the Hospital.

Disease Management (DM) health coaches work with you to help you better manage your chronic disease, such as Asthma, Coronary Artery Disease, Diabetes, and/or Hypertension. A licensed nurse works with you to gain a better understanding of your condition, establish self-management goals, and provide coaching to assist you in making lifestyle modifications.

PresRN

Presbyterian Health Plan members have access to PresRN, a nurse advice line available **24 hours** a day, **7 days** a week, including holidays. PresRN is a no-cost service for Presbyterian Health Plan Members. Please call at **(505) 923-5570** or **1-866-221-9679.**

Health Management Programs

Members have access to resources that support personal health management including online tools, print materials and programs or services to help enhance quality of life in three areas: staying healthy, preventing illness and living with a chronic condition. We help you reach optimum health through educational tools (such as those available on the myPRES Member Portal) Preventive Health Guidelines (such as mammography and childhood immunizations), as well as with disease management for conditions such as Asthma, Coronary Artery Disease, Diabetes, and/or Hypertension.

If you would like more information about these services visit our website at **www.phs.org**. Members can also call our Presbyterian Customer Service Center at **(505) 923-7521 or 1-855-923-7521,** Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Other Programs and Services

TalkSpace

Messaging therapy offers members age 14 and older behavioral health coaching with licensed behavioral therapists via text, video or audio messaging at a time and place that is convenient for them. Go to **https://www.talkspace.com/php** to access the program.

On to Better Health

This interactive software offers an alternative to traditional mental health and substance use disorder care by providing access to tools and resources that are easy to use, confidential and available 24/7. Go to **http://www.ontobetterhealth.com/php**. Create an account and answer a few questions to gain access to the Health Better Services available to you.

Clickotine

Clickotine is an innovative program that uses clinically-driven app technology to help you create and stick to a quit plan and overcome nicotine cravings. Go to **https://www.clktx.com/join** and use Client ID code 731C73 to complete your registration. For more information on how to sign up, contact Customer Service at (505) 923-7787 or 1-855-261-7737.

Assist America

You have the protection of Assist America's global emergency travel assistance services 24 hours a day, 365 days a year. This unique program immediately connects you to services when experiencing a medical emergency while traveling 100 miles or more away from a permanent residence or in another country. First, download the free Assist America Mobile App, then log in with reference number 01-AAPXI-10071. For questions, contact Assist America's Operations Center at 1-800-872-1414 (or +1-609-986-1234 outside of the USA).

MyChart

Members with a Presbyterian Medical Group provider can send electronic messages and communicate with their care team, request prescription renewals and schedule office or telephone visits. You can also view medical records, lab and radiology reports, procedures, and test results. For details, visit **www.phs.org/mychart.**

Wellness at Work

This online tool helps you create personalized health improvement plans and features a powerful Personal Health Assessment (PHA) tool to help identify personal health risks and provide recommendations for improving those risks. To participate, visit **www.phs.org** and register or login onto myPRES.

Covered Benefits

Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services

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

Urgent Care

Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Healthcare Services you receive in an Urgent Care Center or in a Practitioner's/Provider's office for an unforeseen condition due to illness or injury. Urgent conditions are not life-threatening but require prompt medical attention to prevent a serious deterioration in your health.

- Members are encouraged to contact their PCPs for an appointment, if available, before seeking care from another Practitioner/Provider.
- We must Prior-Authorize follow-up care by an Out-of-network (outside of the 5-county area) Practitioner/Provider. **The Member will be responsible for charges that we do not Cover.**

If you believe the condition to be treated is life threatening, you should seek Emergency Healthcare Services as outlined below.

Emergency Healthcare Services

This Agreement covers acute Emergency Healthcare Services **24 hours** per day, **7 days** per week, when those services are needed immediately to prevent jeopardy to your health. You should seek medical treatment from an In-network Practitioner/Provider or facility whenever possible.

If you cannot reasonably access an In-network Facility, we will arrange to Cover the care at an Out-of-network (outside of the 5-county area) facility at the In-network benefit level. Whether Out-of-network (outside of the 5-county area) Emergency Healthcare Service is appropriate will be determined by the Reasonable/Prudent Layperson standard discussed below.

We will provide reimbursement when you receive healthcare procedures, treatments or services delivered after the sudden onset of what reasonably appears to be a medical condition that manifests itself by 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 the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person
- Any circumstance that prevented you from using our established procedures for obtaining Emergency Healthcare Services

Coverage for trauma services and all other Emergency Healthcare Services will continue at least until you are medically stable, do not require critical care, and can be safely transferred to an In-network facility based on the judgment of the attending Physician in consultant with us and in accordance with federal law.

We will provide reimbursement when you, acting in good faith, obtain Emergency Healthcare Services for what reasonably appears to you, acting as a Reasonable/Prudent Layperson, to be an acute condition that requires immediate medical attention, even if your condition is later determined to not be an emergency.

Prior Authorization is not required for Emergency Healthcare Services. If you are admitted as an Inpatient to the Hospital, you or your Practitioner needs to notify us as soon as possible so we can review your Hospital stay.

We will not deny a claim for Emergency Health services when the Member was referred to the emergency room by his or her PCP or by our representative.

If your Emergency Health services results in a hospitalization directly from the emergency room, you are responsible for paying the Inpatient Hospital Cost Sharing amounts (Deductible, Coinsurance and/or Copayment) rather than the emergency room visit Copayment. Refer to your *Summary of Benefits and Coverage* for the Cost Sharing amount.

For Emergency Healthcare Services received Out-of-network (outside of the 5-county area) and/or outside of New Mexico (our Service Area), you may seek Emergency Healthcare Services from the nearest appropriate facility where Emergency Healthcare Services can be rendered. **Non-emergent follow-up care received outside of the 5-county area is not Covered** unless transfer to an In-network Practitioner/Provider would be medically inappropriate and a risk to your health. In such circumstances, we must Authorize the Healthcare Services. **Non-emergent follow-up care outside of the 5-county area is not Covered** for your convenience or preference. **You are responsible for any such charges that we do not Authorize.**

Follow-up care from an Out-of-network (outside of the 5-county area) Practitioner/Provider requires our **Prior Authorization**.

Observation Services

Observation services are defined as Outpatient services furnished by a Hospital and Practitioner/Provider 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
- Determine the need for a possible admission to the Hospital
- When rapid improvement of the patient's condition is anticipated or occurs

When a Hospital places a patient under Outpatient Observation, it is based upon the Practitioner's/Provider's written order. To transition from Observation to an Inpatient admission, our level of care criteria must be met. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient stays. Medical criteria will also be considered. **Observation Services for greater than 24 hours will require Prior Authorization.** It is the responsibility of the facility to notify us.

All Accidental Injury (trauma), Urgent Care, Emergency Healthcare Services, and Observation Services whether provided within or outside of our Service Area are subject to the **Limitations** listed in the **Limitations Section** and the **Exclusions listed in the Exclusions Section**.

Ambulance Services

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

The following types of Ambulance Services are Covered:

- Emergency Ambulance Services
- High-Risk Ambulance Services
- Inter-facility Transfer services

Emergency Ambulance Services are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Healthcare Services under circumstances that would lead a Reasonable/Prudent Layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. Emergency Ambulance Services are Covered only under the following circumstances:

- Within the 5-county area, to the nearest In-network facility where Emergency Healthcare Services and treatment can be rendered, or to an Out-of-network (outside of the 5-county area) facility if an In-network facility is not reasonably accessible. Such services must be

provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

- Outside of the 5-county area, to the nearest appropriate facility where Emergency Healthcare Services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- We will not pay more for air Ambulance Services than we would have paid for ground Ambulance Services over the same distance unless your condition renders the utilization of such ground transportation services medically inappropriate.
- In determining whether you acted in good faith as a Reasonable/Prudent Layperson when obtaining Emergency Ambulance Services, we will take the following factors into consideration:
    - Whether you required Emergency Healthcare Services, as defined above
    - The presenting symptoms
    - Whether a Reasonable/Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health
    - Whether you were advised to seek an Ambulance Service by your Practitioner/Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Agreement
    - Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols

Ambulance Service (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.

High-Risk Ambulance Services are defined as Ambulance Services that are:

- Non-emergency
- Medically Necessary for transporting a high-risk patient
- Prescribed by your Practitioner/Provider

Coverage for High-Risk Ambulance Services is limited to:

- Air Ambulance Service when Medically Necessary. However, we will not pay more for air Ambulance Service than we would have paid for transportation over the same distance by ground Ambulance Services, unless your condition renders the utilization of such ground Ambulance Services medically inappropriate.
- Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility when necessary to protect the life of a newborn.

- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

Inter-facility Transfer Ambulance Services are defined as ground or air Ambulance Service between Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are:

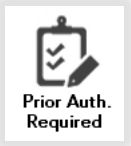
- Medically Necessary
- Prescribed by your Practitioner/Provider
- Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel

Bariatric Surgery

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

Surgical treatment of morbid obesity (bariatric surgery) is Covered only if it is Medically Necessary as defined in this Agreement.

Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m^2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and **Prior Authorization** is required and services must be performed at an In-network facility that is designated as an accredited bariatric surgery Center by the American Society of Metabolic and Bariatric Surgery/American College of Surgeons.



Clinical Trials

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

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 healthcare 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 Healthcare 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 (outside of the 5-county area) 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.

Certified Hospice Care

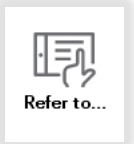
This benefit has one or more exclusions as specified in the Exclusions Section.

Benefits for Inpatient and in-home Hospice services are Covered if you are terminally ill. Services must be provided by an approved Hospice program during a Hospice benefit period and will not be Covered to the extent that they duplicate other Covered Services available to you. Benefits that are provided for by a Hospice or other facility require approval by your Practitioner/Provider and our **Prior Authorization**.
The Hospice benefit period is defined as follows:

- Beginning on the date your Practitioner/Provider certifies that you are terminally ill with a life expectancy of six months or less.
- If you require an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and your Practitioner/Provider must re-authorize your medical condition to us.
- You must be a Covered Member throughout your Hospice benefit period.

The following services are Covered:

- Inpatient Hospice care
- Practitioner/Provider visits by Certified Hospice Practitioner/Providers
- Home Health Care Services by approved home health care personnel
- Physical therapy
- Medical supplies
- Prescription Drugs and Medication for the pain and discomfort specifically related to the terminal illness
- Medical transportation
- Respite care (care that provides a relief for the caregiver) for a period not to exceed **5 continuous days** for every **60 days** of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.



Where there is not a certified Hospice program available, regular Home Health Care Services benefits will apply. Refer to the **Home Health Care Services/Home Intravenous Services and Supplies** Section of this Agreement.

Clinical Preventive Health Services

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

We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.

We will provide Coverage for preventive benefits, as defined by the Affordable Care Act (ACA), without cost sharing regardless of sex assigned at birth, gender identity, or gender of the individual.

Clinical Preventive Health Services Coverage is provided for services under four broad categories:

- Screening and Counseling Services
- Routine Immunizations
- Childhood Preventive Services
- Preventive Services for Women

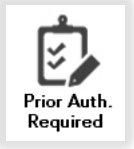
We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/patient/Pages/preventive-care-guidelines.aspx**.

Screening and Counseling Services

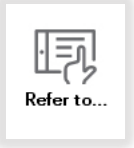
Screenings and counseling services will provide coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force for individuals in certain age groups or based on risk factors. Key screenings include but are not limited to:

- Abdominal aortic aneurism screening for men ages **65 to 75 years** old with a history of smoking.
- Prediabetes and Type 2 diabetes mellitus screening for adults ages **35 to 70 years** old who are overweight or obese.
- Counseling for human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and domestic violence and abuse.
- Heart Artery Calcification scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of 45-65 years. Refer to the Heart Artery Calcification section for more details.

- Falls prevention screening for adults **age 65** or older.
- Hepatitis B screenings for persons at high risk of infection.
- Hepatitis C screenings for adults ages **18 to 79 years** old.
- Latent tuberculosis screening for high-risk populations.
- Lung cancer screenings for ages **50 to 80 years** with a history of smoking.
- Preventive Physical Examinations.
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam.
- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level.
- Periodic stool examination for the presence of blood for all persons **45 years** of age or older.
- One mammogram every two years to persons **age 40** and over.
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:
    - Fecal occult blood testing (FOBT)
    - Flexible sigmoidoscopy
    - Colonoscopy, and polyp removal when performed as a screening
        - anesthesia services are also at no Cost-Share to Covered members when performed as part of Colonoscopy screening
    - Virtual colonoscopy – requires **Prior Authorization**
    - Double contrast barium enema



- Smoking Cessation Program – refer to Smoking Cessation Counseling/Program in this Section.
- Screening to determine the need for vision and hearing correction.
- Syphilis infection screening in persons who are at an increased risk for infection and pregnant women.



- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV, STIs, and counseling, as well as counseling for drug and Tobacco use, healthy eating and other common health concerns.
- Health education and consultation from In-network Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members **19 years** of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices.
- Certain prescription drugs for preventive care, the treatment of illness, behavioral health, or substance use disorders will be Covered at No Charge to you, when obtained from a participating pharmacy. See your Plan's Covered drug list for details.

Routine Immunizations

Routine Immunization includes Coverage for Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of:

- The Advisory Committee on Immunization Practices Centers for Disease Control and Prevention.
- The U.S. Preventive Services Task Force (USPSTF)
    - HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for Well-Child Care in accordance with the recommendations of the U.S. Preventive Services Task Force (USPSTF).
We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/patient/Pages/preventive-care-guidelines.aspx**.

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

- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities.
- Hearing and Vision screening for correction. This does not include routine eye exams or Eye Vision and Hearing screening to determine Refractions performed by eye care specialists. One Eye Refraction per Contract Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases.
- Pediatric Vision – Please refer to the Rider at the end of this Agreement for benefit coverage and details.
- Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum
- Behavioral Assessments
- Screening for Alcohol and drug use, anemia, blood pressure, congenital hypothyroidism, depression, developmental development and surveillance, dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, STIs, Phenylketonuria (PKU) and Tuberculin testing.
- Skin cancer prevention behavioral counseling
- Counseling from Practitioners/Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or

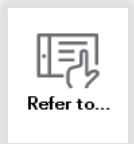
smoking control, nutrition and diet recommendations, and exercise plans. For Members under **19 years** of age, this includes (as deemed appropriate by the Member's Practitioner/Provider or as requested by the parents or legal guardian) education information on Alcohol and Substance Use Disorder, STIs, and contraception.
- Preventive benefits, as defined by the Affordable Care Act (ACA) for all recommended preventive services, including services related to pregnancy, preconception and prenatal care.

Preventive Health Services for Women

We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing at an age and frequency as determined by your In-network Practitioner/Provider.
You can review the recommended clinical preventive health services at **https://www.phs.org/tools-resources/patient/Pages/preventive-care-guidelines.aspx**.
With respect to women, evidence-informed preventive care and screenings for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Key preventive care includes but is not limited to:

- 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.
- Cervical cancer screening for women ages **21 to 65 years** old.
- Chlamydia and gonorrhea screenings for sexually active women age **24 years** or younger and for older women at increased risk for infection.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs. Coverage for contraception is not subject to Cost Sharing, Utilization Review, **Prior Authorization**, step-therapy requirements, or any other restrictions or delays on coverage.
    - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at **https://client.formularynavigator.com/Search.aspx?siteCode=0045707827.**
    - **Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered.**
- Counseling and screening for HIV, STIs and domestic violence and abuse.
- Counseling interventions for pregnant and postpartum persons who are at an increased risk of perinatal depression.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- HIV screening and counseling for sexually active and pregnant women. For pregnant women, the screening will be covered at any point of the pregnancy, even those who present in labor with an unknown status

- HPV DNA test: High-risk HPV DNA testing every **three years** for women with normal cytology results who are **30 or older**.
- HPV vaccine coverage for HPV as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).
- Preeclampsia screenings in pregnant women throughout pregnancy.
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling.
- Sterilization services for women only. Other services, performed during the procedure, are subject to deductible and coinsurance as outlined in your *Summary of Benefits and Coverage*.



You can obtain additional information about Women's Preventive Services recommendations and guidelines on the HealthCare.gov website at **https://www.healthcare.gov/preventive-care-women/**.

Complementary Therapies

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

Acupuncture

Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by your Practitioner/Provider.

It is recommended that Acupuncture be part of a coordinated plan of care approved by your Practitioner/Provider.

Acupuncture must be performed by an appropriately licensed and credentialed healthcare provider (i.e. a doctor of Oriental Medicine).

Acupuncture services are limited to 20 visits per Contract Year unless for rehabilitative or habilitative purposes. There are no limits on services for habilitative or rehabilitative services. The visit limits apply to services for non-habilitative or non-rehabilitative services.

Chiropractic Services

Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic services are subject to the following:

- The Practitioner/Provider determines in advance that Chiropractic treatment can be expected to result in Significant Improvement in your condition within a period of two months.
- Chiropractic treatment is specifically limited to treatment by means of manual manipulation; i.e., by use of hands, and other methods of treatment approved by us including, but not limited to, ultrasound therapy.
- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.

Chiropractic services are limited to 20 visits per Contract Year unless for rehabilitative or habilitative purposes. There are no limits on services for habilitative or rehabilitative services. The visit limits apply to services for non-habilitative or non-rehabilitative services.

Biofeedback

Biofeedback is **only Covered** for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

COVID-19

As a Presbyterian Health Plan member, there will be no cost to you for anything related to COVID-19 screening, testing, medical treatment, or vaccination, including boosters. You will not pay copays, deductibles or coinsurance for visits related to COVID-19, whether at a clinic, hospital or using remote care. If you are on a high deductible plan (HDHP), these services will also be provided to you at no cost.

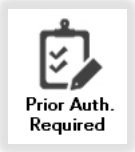
Dental Services (Limited)

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

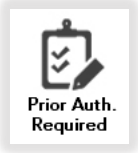
Dental benefits will be provided in connection with the following conditions when deemed Medically Necessary except in an emergency situation as described in the **Accidental Injury (trauma), Urgent Care, Emergency Healthcare Services and Observation Services Section**. Covered Services are as follows:

- Accidental Injury to sound natural teeth, jawbones or surrounding tissue. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury and will not be Covered**.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

- Hospitalization, day surgery, Outpatient and/or anesthesia for non-Covered dental services, are Covered, if provided in a Hospital or ambulatory surgical center for dental surgery, with our approval of a **Prior Authorization** request. Plan benefits for these services include coverage:



    - For Members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
    - For Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
    - For Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
    - For Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
    - For other procedures for which Hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.
- Oral surgery that is Medically Necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an Organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- **Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)**
    - The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthotic Devices (TMJ splints) are subject to the same conditions, limitations, and may require **Prior Authorization** as they apply to treatment of any other joint in the body.



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 the equipment, appliances, 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, supplies and education.

Diabetes Education (Limited).

The following benefits are available when received from a Practitioner/Provider who is approved to provide diabetes education:

- Medically Necessary visits upon the diagnosis of diabetes
- Visits following a Practitioner/Provider diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management
- Visits when re-education or refresher training is prescribed by a healthcare Practitioner/Provider with prescribing authority
- Telephonic visits with a Certified Diabetes Educator (CDE)
- Medical nutrition therapy related to diabetes management

Approved diabetes educators must be part of our In-Network Practitioners/Providers who are registered, certified or licensed Healthcare Professional with recent education in diabetes management.

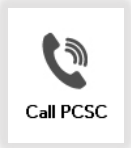
Diabetes supplies and services.

The following equipment, supplies, appliances, and services are Covered when prescribed by your Practitioner/Provider and when obtained through the designated network Provider:

- Preferred Insulin pumps - Some services require **Prior Authorization**. Refer to your *Formulary* for Preferred Insulin pumps
- Specialized monitors/meters for the legally blind
- Medically Necessary Covered Podiatric appliances for prevention of feet complications associated with diabetes. Refer to the **Durable Medical Equipment Benefits Section**.
- 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
- Preferred Continuous Glucose Monitoring (CGM) including system, sensor, and transmitter. Some services require **Prior Authorization**. Refer to the **Prior**

Authorization Section for **Prior Authorization** requirements. Refer to your *Formulary* for Preferred CGM.

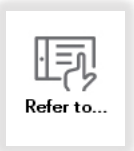
- Visual reading urine ketone strips



These items require the use of approved brands and must be purchased at an In-network Pharmacy, Preferred vendor or Preferred Durable Medical Equipment (DME) supplier. Please contact our Presbyterian Customer Service Center from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. **TTY** users may call **711**. You may also visit their website at **www.phs.org** for further information.

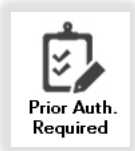
Diagnostic and Imaging Services (tests performed to determine if you have a medical problem or to determine the status of any existing medical conditions)

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



Coverage is provided for Diagnostic Services when Medically Necessary and provided under the direction of your Practitioner/Provider. Some services require **Prior Authorization**. Refer to the **Prior Authorization** Section for **Prior Authorization** requirements.

Examples of Covered procedures include, but are not limited to, the following:



- Computerized Axial Tomography (CAT) scans – requires **Prior Authorization**
- Magnetic Resonance Angiogram (MRA) tests, Magnetic Resonance Imaging (MRI) tests – requires **Prior Authorization**
- Sleep disorder studies in home or facility may require **Prior Authorization**
- Bone density studies
- Clinical laboratory tests – may require **Prior Authorization**
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services

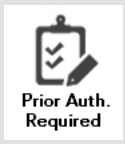
Diagnostic service includes services like mammography, PAP Smears and colonoscopies that are also considered Preventive and are provided to you at $0 Cost Sharing. Some services like exploratory surgery, angiograms, **imaging**, or follow-up procedures to Preventive services can also be diagnostic, but not Preventive and would apply the appropriate Cost-Sharing (Copay, Coinsurance) based on the service.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids

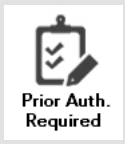
This benefit has one or more exclusions as specified in the Exclusions Section.

Durable Medical Equipment

Durable Medical Equipment is equipment that is Medically Necessary for treatment of an illness or Accidental Injury or to prevent further deterioration. This equipment is designed for repeated use and used to treat a medical condition or illness, and includes items such as oxygen equipment, functional wheelchairs, and crutches. Some durable Medical Equipment may require **Prior Authorization**. Only Durable Medical Equipment considered standard and/or basic as defined by nationally recognized guidelines are Covered.



Orthotic Appliances

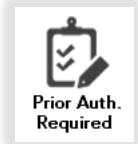


Orthotic Appliances include braces and other external devices used to correct a body function including clubfoot deformity. Orthotic Appliances must be Medically Necessary and may require **Prior Authorization**.

Orthotic Appliances are subject to the following **limitations**:

- Foot Orthotics or shoe appliances are not Covered, except for our Members with diabetic neuropathy or other significant neuropathy.
- Pre-fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for our Members in accordance with nationally recognized guidelines.
- Covered orthotic appliance including:
    - Podiatric appliances for prevention of feet complications associated with diabetes.
    - Repair and replacement of durable medical equipment, prosthetics and orthotic devices with state law. Please see Diabetes Section.

Prosthetic Devices

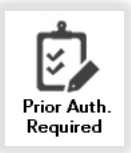


Standard Prosthetic Devices are artificial devices, which replace or augment a missing or impaired part of the body. The purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are Covered when they replace a limb or other part of the body, after accidental or surgical removal, congenital conditions, and/or when the body's growth necessitates replacement. Prosthetic Devices must be Medically Necessary and may require **Prior Authorization**.

Examples of Prosthetic Devices include, but are not limited to:

- Breast prostheses when required because of mastectomy and prophylactic mastectomy
    - Prosthetics related to other Medically Necessary services for Gender Confirmatory therapy and Gender Affirming care are Covered
- Artificial limbs
- Prosthetic eye
- Prosthodontic appliances
- Penile prosthesis
- Joint replacements
- Heart pacemakers
- Tracheostomy tubes and cochlear implants

Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices



Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices requires **Prior Authorization**. Repair and replacement are Covered when Medically Necessary due to change in your condition, wear or after the product's normal life expectancy has been reached.

There are no limitations on the number of pacemakers or joint replacement hardware a member can receive in a plan year, but each replacement must be Medically Necessary. You are required to pay the applicable Coinsurance with each replacement until you reach your out-of-pocket maximum.

One-month rental of a wheelchair is Covered if you owned the wheelchair that is being repaired.

Surgical Dressing

Surgical dressings that require a Practitioner's/Provider's prescription, and cannot be purchased over the counter, are Covered when Medically Necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

Gradient compression stockings are Covered for:

- Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation.
- Venous stasis ulcers that have been treated by a Practitioner/Provider or other Healthcare Professional requiring Medically Necessary debridement (wound cleaning).

Lymphedema wraps and garments prescribed under the direction of a lymphedema therapist are Covered.

Eyeglasses and Contact Lenses (Limited)

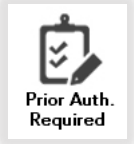
The following will only be Covered:

- Contact lenses are Covered for the correction of aphakia (those with no lens in the eye) or keratoconus. This includes the Eye Refraction examination.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is Covered within 12 months after cataract surgery or when related to Genetic Inborn Error of Metabolism. This includes the Eye Refraction examination, lenses and standard frames.

Hearing Aids

Hearing Aids and the evaluation for the fitting of Hearing Aids are Covered every 36 months per hearing impaired ear. For insured children under 18 years of age or under 21 years of age if still attending high school, coverage is for a Hearing Aid and any related service for the full cost of one Hearing Aid per hearing-impaired ear up to $2,200 every 36 months. This shall include the fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by an In-network Practitioner/Provider licensed in New Mexico.

Electroconvulsive Therapy (ECT)



Electroconvulsive Therapy requires **Prior Authorization.**

Employee Assistance Program

As a Presbyterian Health Plan Member, you and your enrolled dependents have access to an Employee Assistance Program (EAP). EAP services include up to three employee assistance visits per issue. They are provided by local licensed professionals at The Solutions Group, a division of Presbyterian Healthcare Services. These services are short-term, confidential counseling sessions and can include mediation services, substance Use Disorder assessments/referrals and other services. Please contact The Solutions Group at **1-866-254-3555** or **(505) 254-3555** if you have any questions regarding EAP covered services and benefits.

Family, Infant and Toddler (FIT) Program

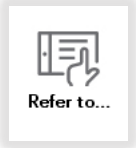
Coverage for children, from birth up to age three under the Family, Infant and Toddler Program (FIT) administered by the Department of Health, provided eligibility criteria are met, is provided for Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel in accordance with state law. Benefits used under this Section will not be applied to your Annual Contract Year Deductible or Annual Out-of-Pocket Maximum.

Genetic Inborn Errors of Metabolism Disorders (IEM)

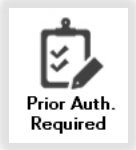
This benefit has one or more exclusions as specified in the Exclusions Section.

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, Exclusions, and Prior Authorization** requirements listed in this Agreement. Medical services provided by licensed Healthcare Professionals, including Practitioners/Providers, dieticians and nutritionists with specific training in managing Members diagnosed with IEM are Covered. Covered Services include:

- Nutritional and medical assessment
- Newborn Screening for Metabolic Diseases
- Clinical services
- Biochemical analysis
- Medical supplies
- Prescription Drugs/Medications – Refer to **Prescription Drugs/Medications Section**



- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism
- Nutritional management
- Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of Genetic Inborn Errors of Metabolism to compensate for the metabolic abnormality and to maintain adequate nutritional status when we approve the **Prior Authorization** request and when provided under the on-going direction of a qualified and licensed healthcare Practitioner/Provider team. This does not include coverage of nutritional items/food supplements that are available over-the counter and/or without prescription.



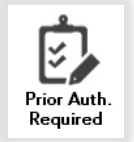
Refer to your *Summary of Benefits and Coverage* for applicable Cost Sharing amounts (office visit Copayments, Inpatient Hospital, outpatient facility, Prescription Drug/Medications and other related Deductibles, Coinsurance and/or Copayments).

Genetic/Genomic Testing

Genetic/genomic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Genetic testing is not used as a screening test. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a

genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. Genetic testing requires **Prior Authorization**.

Habilitative Services



Habilitative services are Healthcare Services that help you keep, learn, or improve skills and functioning for daily living. These services are Covered and may require **Prior Authorization**. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical therapy and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Autism Spectrum Disorder

The diagnosis and treatment for Autism Spectrum Disorder is covered regardless of age in accordance with state mandated benefits as follows:

- Diagnosis for the presence of Autism Spectrum Disorder when performed during a Well-Child or well-baby screening and/or
- 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

Autism Spectrum Disorder Services must be provided by Practitioners/Providers who are certified, registered or licensed to provide these services.

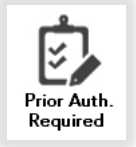
Limitation – Services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children **3 to 22 years** of age who have Autism Spectrum Disorder are not Covered under this Plan.

Heart Artery Calcification Scan

Heart Artery calcification scans are a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function. These scans are Covered for individuals between the ages of 45-65 years and that have an intermediate risk of developing coronary heart disease as determined by a Healthcare Provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to access a persons' 10-year cardiovascular disease risk, including a score calculated using a pool cohort equation. The scans are Covered only once every five years if an eligible Member has previously received a heart artery calcium score of zero. Coverage will not be provided for future heart artery calcium scans if an eligible member receives a heart artery calcium score greater than zero. Heart Artery calcification is a Covered preventive benefit with no member Cost-Sharing.

Home Health Care Services/Home Intravenous Services and Supplies

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



Home Health Care Services are Healthcare Services provided to you when you are confined to the home due to physical illness. Home Health Care Services requires **Prior Authorization** and your Practitioner's/Provider's approved plan of care.

Any Practitioner's/Provider's prescription and **Prior Authorization** must be renewed at the end of each **60-day** period. We will not impose a limitation on the number of related hours per visit.

Home Health Care Services shall include Medically Necessary skilled intermittent Healthcare Services provided by a registered nurse or a licensed practical nurse; physical, occupational, and/or respiratory therapist and/or speech pathologist. Intermittent Home Health aide services are only Covered when part of an approved plan of care which includes skilled services.

Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis.

Medical equipment, Prescription Drugs and Medications, laboratory services and supplies deemed Medically Necessary by a Practitioner/Provider for the provision of health services in the home, except Durable Medical Equipment, will be Covered.

The following Home Health Care Services will be Covered when we approve a **Prior Authorization** request:

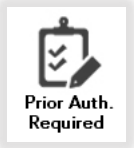
- Home health care or home intravenous services as an alternative to Hospitalization, as determined by your Practitioner/Provider
- Total parenteral and enteral nutrition as the sole source of nutrition
- Medical Drugs: (Medications obtained through the medical benefit): A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization** and some must be obtained through the specialty network.
    - For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our In-network Specialty network, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739**

- You may call our Presbyterian Customer Service Center for more information at **(505) 923-7521 or 1-855-923-7521,** Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Hospital Services – Inpatient

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

Inpatient means you have been admitted by a healthcare Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services are acute care services provided when you are a registered bed patient and there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital.



Hospital admissions (Inpatient, non-emergent) require **Prior Authorization**.

Inpatient services provided by Out-of-network (outside of the 5-county area) Practitioners/Providers or facilities are not Covered except as provided in **How This Plan Works, Accidental Injury / Urgent Care /Emergency Health Services / Observation / Trauma Services, and Eligibility, Enrollment and Termination and Continuation Sections** of this Agreement.

Inpatient Hospital benefits also includes Acute medical detoxification.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of The Undersea and Hyperbaric Medical Society (UHMS). Hyperbaric Oxygen Therapy is **Excluded** for any other condition. Hyperbaric Oxygen Therapy requires **Prior Authorization** and services must be provided by your In-network Practitioner/Provider in order to be Covered.

Infertility

Diagnosis and medically indicated treatments for physical conditions causing infertility. Diagnostic workup (i.e. hormone replacement) is not Covered.

Mental Health Services and Alcohol and Substance Use Disorder Services

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

No Cost Sharing For Behavioral Health Services

Cost Sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, substance use disorders and trauma spectrum disorders. This includes Cost Sharing for inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and prescription drugs that are subject to No Cost Sharing for Behavioral Health Services.

Cost Sharing means any copayment, coinsurance, deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

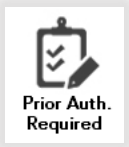
Mental Health Services

Some mental health services require **Prior Authorization**. The In-network Behavioral Health Practitioners/Providers will be responsible for obtaining **Prior Authorization**, when required. For Out-of-network (outside of the 5-county area) Services, Members need to contact our Behavioral Health Department to obtain **Prior Authorization**, when required. Please refer to the **Prior Authorization** Section for services that require **Prior Authorization**. For assistance or for questions related to mental health services you may call our Behavioral Health Department directly at **(505) 923-5470** or **1-800-453-4347**.

For assistance with accessing or for questions related to mental health services, you may do the following:

- Schedule an appointment with a behavioral health provider
- Call your primary care provider (PCP).
- Call our Behavioral Health Department directly at **(505) 923-5470** or **1-800-453-4347**.

Partial Hospitalization can be substituted for the Inpatient mental health services when our Behavioral Health Department approves the **Prior Authorization** request. Partial Hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies.



Acute medical detoxification benefits are Covered under Inpatient and Outpatient Medical services found in the Benefits Section of this Agreement and will cover no less than **30 days** in an alcohol dependency treatment center and no less than **30 outpatient** visits for alcohol dependency treatment. Some services require **Prior Authorization** except when requesting emergency services.

Alcohol and Substance Use Disorder Services

To obtain Alcoholism/Substance Use Disorder services, Members may contact our Behavioral Health Department at **(505) 923-5470** or **1-800-453-4347**. The Behavioral Health Practitioner/Provider will be responsible for any additional **Prior Authorizations**. Inpatient detoxification services require **prior authorization** except when requesting emergency services.

For Out-of-network (outside of the 5-county area) Services, Members need to contact our Behavioral Health Department in order to obtain **Prior Authorization**, when required. Please refer to the **Prior Authorization Section**.

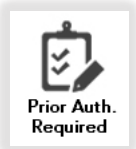
In all cases, treatment must be Medically Necessary in order to be Covered.

Acute Medical Detoxification Benefits are Covered under Inpatient and Outpatient Hospital Services found in the Benefits Section of this Agreement and will cover no less than **30 days** in an alcohol dependency treatment center and no less than **30 outpatient** visits for alcohol dependency treatment. Inpatient Hospital Services must be **Prior Authorized** except when requesting emergency services. Presbyterian will not use more restrictive limitations on mental health and substance use disorder benefits than on medical or surgical benefits, including visit limitations, utilization review, or prior authorization.

Nutritional Support and Supplements

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

Nutritional Supplements for prenatal care when prescribed by a Practitioner/Provider are Covered for pregnant women.

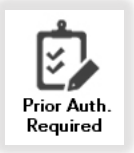


Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by an In-network Practitioner/Provider and when Medically Necessary to replace a specific documented deficiency. **Prior Authorization is required.**

Nutritional supplements administered by injection at the Practitioner's/Provider's office are Covered when Medically Necessary.

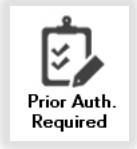
Enteral formulas or products, as Nutritional support, are Covered only when prescribed by an In-network Practitioner/Provider and administered by enteral tube feedings as the sole source of nutrition.

Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is Covered when ordered by an In-network Practitioner/Provider.



Special Medical Foods as listed as Covered benefits in the Genetic Inborn Errors of Metabolism (IEM) Benefit of this Section. **Prior Authorization is required.**

Orthotics

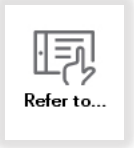


Some Pre-fabricated Orthotics require **Prior Authorization.**

Outpatient Medical Services

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

Outpatient Medical Services are services provided in a Hospital, outpatient facility, Practitioner's/Provider's office or other appropriately licensed facility. These services do not require admission to any facility.



Outpatient Medical services include reasonable Hospital services provided on an ambulatory (outpatient) basis and those preventive, Medically Necessary diagnostic and treatment procedures that are prescribed by your In-network Practitioner/Provider. Refer to the **Prior Authorization Section** for services that require **Prior Authorization**.

Outpatient services provided by Out-of-network (outside of the 5-county area) Providers/Practitioners are not Covered except as provided in **How the Plan Works, Eligibility and Enrollment, and Accidental Injury / Urgent Care / Emergency Health Services / Observation / Trauma Services Benefit Sections**.

Outpatient Medical benefits include, but are not limited to, the following services:

- Chemotherapy and radiation therapy - Chemotherapy is the use of chemical agents in the treatment or control of disease.
- Hypnotherapy (Limited) - Hypnotherapy is only Covered when performed by an anesthesiologist or psychiatrist, trained in the use of hypnosis when: Used within two weeks prior to surgery for chronic pain management and for chronic pain management when part of a coordinated treatment plan.
- Dialysis
- Diagnostic Services – Refer to the **Diagnostic Services Section**
- Medical Drugs (Medications obtained through the medical benefit).
    - A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization** and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require **Prior Authorization** and what drugs are mandated to our Specialty network, please see the Presbyterian Pharmacy website at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739** These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in your *Summary of Benefits and Coverage*
- Observation following Outpatient Services
- Sleep disorder studies, in home or outpatient facility (sleep studies done in a facility require **Prior Authorization**)
- Surgery
- Therapeutic and support care services, supplies, appliances, and therapies
- Wound care

Positron Emissions Tomography (PET) Scans in an Outpatient Setting

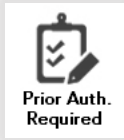
Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that quantifies biochemical processes in living tissue. Positron Emission Tomography (PET) scans in an outpatient setting require **Prior Authorization**.

Practitioner/Provider Services

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

Practitioner/Provider services are those services that are reasonably required to maintain good health. Practitioner/Provider services include, but are not limited to, periodic examinations and office visits by:

- A licensed Practitioner/Provider
- Specialist services provided by other Healthcare Professionals who are licensed to practice, are certified, and practicing as authorized by applicable law or authority
- A medical group
- An independent practice association
- Other authority authorized by applicable state law



Some Practitioner/Provider services require **Prior Authorization**. Refer to the **Prior Authorization Section** for **Prior Authorization** requirements. This Benefit includes, but not limited to, consultation and Healthcare Services and supplies provided by your Practitioner/Provider as shown below:

- Office visits provided by a qualified Practitioner/Provider.
- Presbyterian Health Plan (PHP) Video Visits provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters. PHP Video Visits utilizes Walmart Health Virtual Care's nationwide network of Providers.
- Telehealth appointments through video or phone are with a network Provider, including Presbyterian Medical Group Providers.
- Online visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider.
- behavioral health services will be provided via telemedicine on the same terms as physical health services in compliance with the telemedicine parity and mental health parity laws
- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Anesthesia may include hypnotherapy.
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care
- Allergy Services, including testing and serum
- Sterilization procedures
- Student Health Centers: Dependent Students attending school either in the 5-county area or outside the 5-county area may receive care through their PCP or at the Student Health Center. A **Prior Authorization** is not needed prior to receiving care from the Student Health Center. Services provided outside of the Student Health Center are limited to Medically Necessary Covered services for the initial care or treatment of an Emergency Healthcare Service or Urgent Care situation.
- Second medical opinions. Cost Sharing will apply when you or your Practitioner/Provider requests the second medical opinion. Cost Sharing will not apply if we require a second medical opinion to evaluate the medical appropriateness of a diagnosis or service.

Prescription Drugs/Medications

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

Covered Prescription Drugs/Medications

Prescription Drug/Medications Benefit (Outpatient)

Outpatient Prescription Drugs are a Covered Benefit when prescribed by your Provider. Refer to your *Formulary* for information on the approved Prescription Drugs.

For a complete list of these drugs, please see the Health Insurance Exchange Metal Level Plan Formulary list at
https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101

Affordable Care Act (ACA)

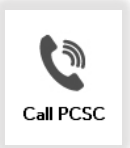
We will provide Coverage for preventive medications and products as defined by the Affordable Care Act (ACA) if you receive these services from our In-network Practitioners/Providers, without Cost Sharing regardless of sex assigned at birth, gender identity, or gender of the individual.

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.

Visit the *formulary* listing at
https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101
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.

Oral Contraceptives

Methods of preferred generic oral contraceptives, injectable contraceptives, or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at **https://client.formularynavigator.com/Search.aspx?siteCode=0045707827.**



You can contact our Presbyterian Customer Service Center from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. **TTY** users may call **711**.

Contraception Coverage

You are entitled to receive certain covered contraception services and supplies without cost sharing and without Prior Authorization from us. This means that you do not have to make a copayment, coinsurance, satisfy a deductible or pay out-of-pocket for any part of contraception benefits listed in this summary if you receive them from an In-network Provider.
You may be required to pay a copay, coinsurance, and/or a deductible if you receive a contraception service or supply from an Out-of-network Provider if the same service or supply is available In-network.

You may also owe cost sharing if you receive a brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

Covered Contraceptive Methods

Your plan covers these contraceptive methods:

- Sterilization Surgery for Women
- Sterilization Surgery for Men
- IUD Copper
- IUD with Progestin
- Implantable Rod
- Shot/Injection
- Oral Contraceptives (The Pill) (Combined Pill)
- Oral Contraceptives (Extended/Continuous Use)
- Oral Contraceptives (Mini Pill – Progestin Only)
- Patch
- Vaginal Contraceptive Ring
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Male Condom
- Female Condom
- Spermicide
- Emergency Contraceptive – “Plan B”
- Emergency Contraceptive – “Ella”

Long Acting Reversible Contraceptives

The Long Acting Reversible Contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without Cost-Sharing are listed here: **https://client.formularynavigator.com/Search.aspx?siteCode=0045707827**. Coverage with no cost-sharing also applies to IUD insertion and removal ,including surgical removal, and to any related medical examination when services are obtained from an In-network Provider. Coverage of LARCs with no Cost Sharing also includes (pre-discharge) postpartum clinical services.

Six Month Dispensing

You are entitled to receive a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. To receive this benefit, your provider must specifically prescribe the six-month supply. If you need to change your contraceptive method before the six-month supply runs out, you may do so without cost-sharing. You will not owe cost sharing for any related contraceptive counseling or side-effects management.

Brand Name Drugs or Devices

Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Refer to the list of contraceptive methods above. Ask your Provider about a possible equivalent.
If your Provider determines that a brand-name contraceptive is Medically Necessary, your Provider may ask us to cover that contraceptive without Cost Sharing. If we deny the request, you or your Provider can submit a grievance to contest that denial.

Vasectomies and Male Condoms

This plan covers vasectomies and male condoms. No prescription or cost sharing is required for coverage of male condoms. Please see the section below on *Coverage for Contraception Where a Prescription Is Not Required* for instructions on reimbursement for condoms.

Sexually Transmitted Infections (STIs)

Your plan covers contraception methods that are prescribed for the prevention of Sexually Transmitted Infections (STIs). No Cost Sharing applies.

Coverage for Contraception Where a Prescription Is Not Required

Your plan covers contraception with no cost sharing even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a prescription when obtained through an in-network pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within **90 days** of the date of purchase of the contraceptive method
- Provide the receipt with the item name and amount, your name, address, plan ID number, to the following:

Address: Presbyterian Health Plan
Attn.: Pharmacy Dept.
P.O. Box 27489

Albuquerque, NM 87125-7489

Email: **askpharmacy@phs.org**
Fax: **505-923-5540**

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within **30 days** of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within **45 days**. Please ensure all information on the reimbursement request is complete to prevent delays in reimbursement.

Availability of Out-of-Network Coverage

Under your plan, use of an Out-of-network Provider to prescribe or dispense contraceptive coverage is a Covered benefit. Please refer to *Summary of Benefits and Coverage* to learn more about your Out-of-network benefit.

Orally Administered Anti-Cancer Medications.

This Plan provides coverage for orally administered anti-cancer medications 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.

Insulin for Diabetes Cost Sharing Cap

The Copayment amount for a preferred *formulary* prescription insulin drug or a Medically Necessary alternative will be Covered at an amount not to exceed **$25.00*** per **30-day** supply.

*Copayments are subject to Deductible first.

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 physicians, 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 **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101**

Presbyterian 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 it 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 patient protection and generic versions become available.
- Changes based on 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 Charing 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 physicians, clinical pharmacists and other professionals in the healthcare field.

The P&T Committee meets quarterly to promote the appropriate use of drugs, to maintain the Presbyterian formularies, and to support our network of practitioners. 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.

Changes to the Presbyterian *formulary* are made effective at least **45 days** after the quarterly meeting. If a change to the *formulary* negatively impacts utilizing members, the members are granted a **60-day** transition period. Members impacted will receive a *Formulary* Change Notification letter with details about the change, the effective date of the change and *formulary* alternatives if available.

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Healthcare 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 Healthcare Service in consultation with your medical provider, 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.

- Continuation of therapy using any drug is dependent upon its demonstrable efficacy.
- Prior use of free prescriptions medications (i.e. Samples, free goods, etc.) will not be considered in the evaluation of a member's eligibility for medication coverage.

Prescribed drugs will be considered for coverage under the pharmacy benefit when all of the following are met:
The medication is being prescribed for an FDA approved indication OR the patient has a diagnosis which is considered medically acceptable in the approved compendia* or a peer-reviewed medical journal.

- The patient does not have any contraindications or significant safety concerns with using the prescribed drug.
- If the patient does not meet the above criteria, the prescribed use is considered Experimental or Investigational for Conditions not listed in this section of Evidence of Coverage.
- *The approved compendia includes:
    - American Hospital Formulary Service (AHFS) Compendium.
    - IBM Micromedex Compendium.
    - Elsevier Gold Standard's Clinical Pharmacology Compendium.
    - National Comprehensive Cancer Network Drugs and Biologics Compendium.

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 doctor and pharmacist check that the medications are used appropriately and promote patient

safety. Presbyterian 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.

Non-Extended Day Supply

Presbyterian has established protocols under the guidance of National Committee for Quality Assurance (NCQA) in an effort 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 Individual and Family Metal Plans/Employer Group Metal Plans *Formulary* as Non-Extended Day Supplies.

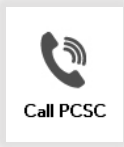
No Behavioral Health Cost Sharing

Formulary prescription drugs used for the treatment of mental illness, behavioral health, or substance use disorders when obtained from a behavioral health specialist may be covered at no cost share. Coverage at no Cost Share is Subject to applicable benefit plans. Refer to the formulary listing at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101** for additional coverage details.

What if my Drug is not Covered

You or your doctor can ask us to make an exception (prior authorization) to our coverage rules. We will work with your prescriber to get additional information to support your request. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our *formulary*.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.



For more information contact our Presbyterian Customer Service Center at **(505) 923-7521 or 1-855-923-7521**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call our TTY line at **711**.

Additional information explaining the exception process can be found at **http://www.phs.org/tools-resources/member/Pages/pharmacy.aspx**.

Drug Utilization Review (DUR) and Drug Use Evaluation Programs

DUR is a review of patient data which is done to evaluate the effectiveness, safety and appropriateness of medication use. These Drug Utilization Reviews occur during claim adjudication and determines 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 DUR reviews often alert 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 Health Insurance Exchange Metal Level *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

A generic equivalent will be dispensed if available. If your prescriber requests to dispense a brand-name drug when a generic equivalent is available, the request will require a Medical Exception.

If Medical necessity is established, the non-preferred drug copay plus the difference between the brand-name and the generic drug will apply. Otherwise, brand-name drugs when a generic is equivalent is available are not covered and will not count towards the deductible or annual out-of-pocket maximums.

Medication Synchronization

Medication Synchronization allows Members to refill all of 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 Sharing

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

Benefit Limitations

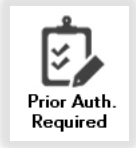
This benefit has one or more exclusions as specified in the Exclusions Section.

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

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 maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

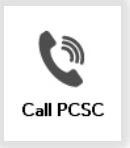
Self-Administered Specialty Pharmaceuticals

Self-Administered Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or 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 may have additional day supply limitations.
- Most Specialty Pharmaceuticals must be obtained through the Specialty Pharmaceutical network.

For a complete list of these drugs, please see the Specialty Pharmaceutical listing at **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101**



You can call our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**.

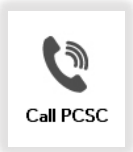
Office Administered Specialty Pharmaceuticals (Medical Drugs)

A **Medical Drug** is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization** and some must be obtained through the specialty network. These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in your *Summary of Benefits and Coverage*.

For a complete list of Medical Drugs to determine which require **Prior Authorization,** please see the Presbyterian Pharmacy website at
https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00052739

Mail Order Pharmacy

You 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 Customer Service Center at **(505) 923-7521 or 1-855-923-7521,** Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **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 (outside of the 5-county area) Pharmacy, and they are unable to process the claim at point of service you can 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 copay or coinsurance that may apply. Members will not be liable to a Provider for any sums owed to the Provider by Presbyterian.

The form together with the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) must contain the following information:

- Patient's name
- Patient's Date of Birth
- Name of the drug
- Quantity dispensed

- NDC (National Drug Code)
- Fill Date
- Name of Prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of Payment

Member Reimbursement forms are available by calling our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711**.

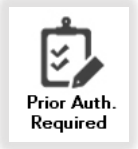
The Presbyterian Health Plan Pharmacy Service Team is available **24 hours** a day to providers and pharmacies to address pharmacy benefit questions and **Prior Authorization** requests. Please contact **(505) 923-7521 or 1-855-923-7521** and follow the voice prompts and select Pharmacy.

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

Presbyterian 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 Physician or the physician's authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician 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 professionals, Presbyterian shall allow the PCP or other participating healthcare professional to refer a member to a non-participating healthcare professional and shall fully reimburse the non-participating healthcare professional at the usual, customary, and reasonable rate or at an agreed-upon rate. Before Presbyterian may deny such a referral to a non-participating physician or healthcare professional, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

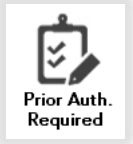
Proton Beam Irradiation



Proton Beam Therapy is a type of radiation that utilizes protons to deliver ionizing damage to a target. Proton Beam Irradiation requires **Prior Authorization**.

Reconstructive Surgery

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



Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be Covered if performed for the correction of functional disorders. Reconstructive Surgery must be prescribed by a Member's Practitioner/Provider and requires **Prior Authorization**. For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the **Women's Healthcare Section**.

Reconstructive surgery related to Gender Confirmatory Therapy and Gender Affirming Care are Covered. The **Prior Authorization** criteria of this Plan is applicable

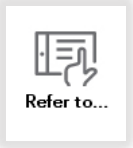
Rehabilitation and Therapy

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

Cardiac Rehabilitation Services

Cardiac Rehabilitation benefits are available for continuous electrocardiogram (ECG) monitoring, progressive exercises and intermittent ECG monitoring. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost Sharing amount.

Pulmonary Rehabilitation Services



Pulmonary Rehabilitation benefits are available for progressive exercises and monitoring of pulmonary functions. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost Sharing amount.

Short-term Rehabilitation Services

Short-term Rehabilitation benefits are available for physical therapy, occupational therapy, and speech therapy, provided in a Rehabilitation Facility, Skilled Nursing Facility, Home Health Agency, or Outpatient setting. Short-term Rehabilitation is designed to assist you in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example,

stroke, motor vehicle accident, or heart attack). Coverage is subject to the following requirements and **limitations**:

- Outpatient physical and occupational therapy require that your Primary Care Practitioner or other appropriate treating Practitioner/Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost Sharing amount.
- The treatment plans that define expected Significant Improvement must be established at the initial visit. Therapy treatments must be provided and/or directed by a licensed physical or occupational therapist.
- Treatments by a physical or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
- Massage Therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed Short-term Rehabilitation physical therapy program. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost Sharing amount.
- Outpatient Speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is Covered when provided by a licensed or certified speech therapist.
- Your PCP must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition. Refer to the rehabilitation and habilitation section of your *Summary of Benefits and Coverage* for your Cost Sharing amount.

If your Short-Term Rehabilitation therapy is provided in an Inpatient setting (such as, but not limited to, Rehabilitation Facilities, Skilled Nursing Facilities, intensive day-Hospital programs that are delivered by a Rehabilitation Facility) or through Home Health Care Services, the therapy is not subject to time limitation requirements. These Inpatient and Home Health therapies are not included with Outpatient services when calculating the total accumulated benefit usage.

Selected Surgical/Diagnostic Procedures

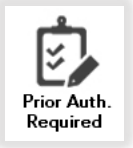
Presbyterian also covers other surgical/diagnostic procedures, which may be subject to **Prior Authorization**:

- Bariatric Surgery
- Blepharoplasty/Brow Ptosis Surgery
- Breast Reconstruction following Mastectomy
- Breast reduction for gynecomastia
- Cholecystectomy by Laparoscopy
- Endoscopy Nasal/Sinus balloon dilation
- Gender Confirmation Surgery
- Hysterectomy

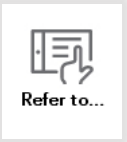
- Lumbar/Cervical Spine Surgery
- Meniscus Implant and Allograft/Meniscus Transplant
- Panniculectomy
- Rhinoplasty
- Tonsillectomy
- Total Ankle Replacement
- Total Hip Replacement
- Total Knee Replacement

Skilled Nursing Facility Care

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



Room and board and other necessary services furnished by a Skilled Nursing Facility are Covered and require **Prior Authorization**. Admission must be appropriate for your Medically Necessary care and rehabilitation.



Refer to your *Summary of Benefits and Coverage* for your visit limitations.

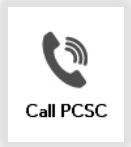
Smoking Cessation Counseling/Program

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

Coverage is provided for Diagnostic Services, Smoking Cessation Counseling and pharmacotherapy. Medical services are provided by licensed Healthcare Professionals with specific training in managing your Smoking Cessation Program. The program is described as follows:

- Individual counseling at an In-network Practitioner's/Provider's office is Covered under the medical benefit. The Primary Care Practitioner or the In-network specialist Copayment applies.
- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Practitioner/Provider. No Cost Sharing will apply and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.

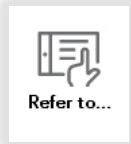
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services.



For more information contact our Presbyterian Customer Service Center at **(505) 923-7521 or 1-855-923-7521**, Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

Pharmacotherapy benefit Limitations

- Prescription Drugs/Medications purchased at an In-network Pharmacy
- Two **90-day** courses of treatment per Contract Year



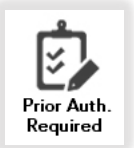
Refer to your *Summary of Benefits and Coverage* and your *Formulary* for your Cost Sharing amount.

Telemedicine Services

PHP provides coverage for telemedicine services to the same extent that this agreement covers the same services when provided in-person or In-network. PHP will not impose originating-site restrictions. Coverage may be extended to out-of-network providers in instances where no in-network provider is accessible, as defined by network adequacy standards. A determination by PHP that services delivered through the use of telemedicine are not covered is subject to review and appeal.

Transplants

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



All Organ transplants must be performed at an approved center and require **Prior Authorization**.

Human Solid Organ transplant benefits are Covered for:

- Kidney
- Liver

- Pancreas
- Intestine
- Heart
- Lung
- multi-visceral (3 or more abdominal Organs)
- simultaneous multi-Organ transplants – unless investigational
- pancreas islet cell infusion
- Meniscal Allograft
- Autologous Chondrocyte Implantation – knee only
- Hematopoietic Transplant Benefits are Covered for:
    - Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are Covered for the following indications:
    - multiple myeloma
    - leukemia
    - aplastic anemia
    - lymphoma
    - severe combined immunodeficiency disease (SCID)
    - Wiskott Aldrich syndrome
    - Ewing's Sarcoma
    - germ cell tumor
    - neuroblastoma
    - Wilms Tumor
    - myelodysplastic Syndrome
    - myelofibrosis
    - sickle cell disease
    - thalassemia major

If there is a living donor that requires surgery to make an Organ available for a Covered transplant for our Member, Coverage is available for expenses incurred by the living donor for surgery, laboratory and X-ray services, Organ storage expenses, and Inpatient follow-up care only. We will pay the Total Allowable Charges for a living donor who is not entitled to benefits under any other health benefit plan or policy.

Limited travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be Covered for both out-of-state and instate, up to a maximum of **$150** per day for the transplant recipient, live donor and one other person combined. Benefits will only be Covered for transportation, lodging and meals and are **limited** to a lifetime maximum of **$10,000**. All Organ transplants must be performed at site that we approve and require **Prior Authorization**.

Women's Healthcare

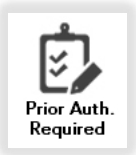
The following Woman's Healthcare Services, in addition to services listed in the Preventive Care and other Sections of this Agreement are available for our female Members under the Women's Health and Cancer Rights Act (WHCRA). Inpatient Hospital services require **Prior Authorization**.

Gynecological care includes:

- Annual exams
- Care related to pregnancy
- Miscarriage
- Therapeutic abortions
- Elective abortions up to 24 weeks
- Other gynecological services

Prenatal Maternity care benefits include:

- Prenatal care
- Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between sixteen and twenty weeks of pregnancy, to screen for certain abnormalities in the fetus)
- Visits to an Obstetrician
- Certified Nurse-midwife
- Licensed Midwife
- Medically Necessary nutritional supplements as determined and prescribed by the attending Practitioner/Provider. Prescription nutritional supplements require **Prior Authorization**.
- Childbirth in a Hospital or in a licensed birthing center



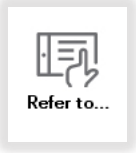
Maternity Care

In Accordance with the Newborns' and Mothers' Health Protection Act (the Newborns' Act), the following services are available:

- Maternity Coverage is available to a mother and her newborn (if a Member) for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a cesarean section. Maternity In-patient Hospital admissions and birthing center admissions require notification to appropriately manage care. Your provider will provide notification to the Health Plan of your maternity admission. Please see coverage for emergent/**prior authorization** admissions.
- In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Practitioner/Provider. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and

the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family Members or other support person(s) will be available to the mother for the first few days following early discharge.

- Maternity Inpatient care in excess of **48 hours** following a vaginal delivery and **96 hours** following a cesarean section will be Covered if determined to be Medically Necessary by the mother's attending Practitioner/Provider. An additional stay will be considered a separate Hospital stay and requires **Prior Authorization**. Refer to your *Summary of Benefits and Coverage* for Cost Sharing information.



- High-risk Ambulance services are Covered in accordance with the **Ambulance Services Benefits Section**.
- The services of a Licensed Midwife or Certified Nurse Midwife are Covered, for the following:
    - The midwife's services must be provided strictly according to their legal scope of practice and in accordance with all applicable state licensing regulations which may include a supervisory component.
    - The services must be provided in preparation for or in connection with the delivery of a newborn.
    - For purpose of Coverage under this Agreement, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are not Covered. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.
    - The combined fees of the midwife and any attending or supervising Practitioners/Providers, for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Practitioner/Provider had he/she been the sole Practitioner/Provider of those services.

Newborn Care

A newborn of a Member will be Covered from the moment of birth when enrolled as follows:

- We must receive the signed and completed enrollment Application for the newborn that was submitted to the employer Group within **31 days** from the date of birth.
- If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed enrollment Application within the first **31 days** following the date of birth.

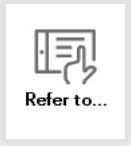
- If the above conditions are not met, we will not enroll the newborn for Coverage until the next Annual Group Enrollment Period.
- Neonatal care is available for the newborn of a Member for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains

in the Hospital, it is considered a separate Hospital stay and requires **Prior Authorization**. Refer to your *Summary of Benefits and Coverage* for your Cost Sharing amount.

- Benefits for a newborn who is a Member shall include Coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant Coverage includes transportation, including air Ambulance Services to the nearest available Tertiary facility. Newborn Member benefits also include Coverage for newborn visits in the Hospital by the baby's Practitioner/Provider, circumcision, incubator, and routine Hospital nursery charges.
- A newborn of a Member's Dependent child **cannot** be enrolled unless the newborn is legally adopted by the Subscriber, or the Subscriber is appointed by the court as the newborn's legal guardian.

Additional Women's Healthcare Benefits

- Mammography and Diagnostic Mammography Coverage.
- Mastectomy, Prophylactic Mastectomy, Prosthetic Devices and Reconstructive surgery. Some care requires **Prior Authorization**.
    - Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than **48 hours** of Inpatient care following a mastectomy and not less than **24 hours** of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless you and the attending Practitioner/Provider determine that a shorter period of Hospital stay is appropriate.
    - Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Cost Sharing amounts consistent with those imposed on other benefits. Refer to your *Summary of Benefits and Coverage* for Cost Sharing amounts.



    - Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). Two bras per year are Covered for Members with external breast prosthesis.
    - As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.
    - Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy.
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary.
- The Alpha-fetoprotein IV screening test for pregnant women, generally between 16 and 20 weeks for pregnancy, to screen for certain genetic abnormalities in the fetus.
- Non-Invasive Prenatal Testing (NIPT) (may require **Prior Authorization**).
- Coverage for the preventive screening of women who have family members with breast, ovarian, tubal or peritoneal cancers with one of several screening tools designed to

identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2) (may require **Prior Authorization**).

- Women with positive screening results may receive genetic counseling and, if indicated after counseling, BRCA testing as determined by her healthcare provider (may require **Prior Authorization**).

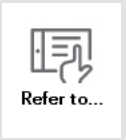
General Limitations

This Section explains the general limitations that apply to your Covered Benefits and other Sections of this Agreement.

Benefit Limitations

Your Covered Benefits may have specific limitations or requirements and are listed under the specific benefit section of this document:

- Some Benefits may be subject to dollar amount and/or visit limitations.
- Benefits may be excluded if the services are provided by Out-of-network (outside of the 5-county area) Practitioners/Providers.
- Some Benefits may be subject to **Prior Authorization**.



Refer to your *Summary of Benefits and Coverage* and the **Benefits Section** for details about these limitations.

Coverage while away from the Service Area

When you are away from the Service Area, Covered Benefits are limited to Emergency Healthcare Services and Urgent Care.

Major Disasters

In the event of any major disaster, epidemic or other circumstances beyond our control, we shall render or attempt to arrange Covered Benefits with In-network Practitioners/Providers insofar as practical, according to our best judgment, and within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such service due to the lack of available facilities or personnel if such lack is the result of such disaster, epidemic or other circumstances beyond our control, and if we have made a good-faith effort to provide or arrange for the provision of such services. Such circumstances include complete or partial disruption of facilities, war, act(s) of terrorism, riot, civil insurrection, disability of a significant part of a Hospital, our personnel or In-network Practitioners/Providers or similar causes.

Prior Authorization

Benefits for certain services and supplies are subject to **Prior Authorization** as specified in the **Prior Authorization Section**. Benefits may not be payable for services from Out-of-network (outside of the 5-county area) Practitioners/Providers if you fail to obtain **Prior Authorization**.

Exclusions

This Section lists services that are not Covered (Excluded Services) under your Health Benefit Plan. All other benefits and services not specifically listed as Covered in the Benefits Section shall be Excluded Services.

Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not Medically Necessary when subject to medical necessity review, is not Covered. This includes any service, which is not recognized according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Healthcare Insurer consistent with such federal, national, and professional practice guidelines, or any service for which the required approval of a government agency has not been granted at the time the service is provided.

Accidental Injury (Trauma), Urgent Care, Emergency Healthcare Services, and Observation Services

Emergency Healthcare Services – Use of an emergency facility for non-emergent services is not Covered. This does not include situations in which a covered person, acting in good faith and possessing an average knowledge of health and medicine, visits the emergency room for what appears to be an acute condition that requires immediate medical attention.

Ambulance Services

Ambulance service (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.

Autopsies

Autopsy costs for Covered Members are not Covered.

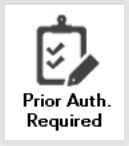
Before or After the Effective Date of Coverage

Services received, items purchased, prescriptions filled or healthcare expenses incurred before your effective date of Coverage or after the termination of your Coverage are not Covered.

Clinical Trials

Any Clinical Trials provided outside of the 5-county area, as well as those that do not meet the requirements indicated in the Benefits Section, are not Covered.

Costs of the Clinical Trial that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources are not Covered.



Services from Out-of-network (outside of the 5-county area) Practitioners/Providers, unless services from an In-network Practitioner/Provider is not available are not Covered. **Prior Authorization** is required for any Out-of-network (outside of the 5-county area) Services and such services must be provided for in the 5-county area unless in an urgent or emergent situation as defined by your benefits.

The cost of a non-FDA approved Investigational drug, device or procedure is not Covered.

The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Clinical Trial is not Covered.

Costs associated with managing the research that is associated with the Clinical Trials are not Covered.

Costs that would not be Covered if non-Investigational treatments were provided are not Covered.

Costs of tests that are necessary for the research of the Clinical Trial are not Covered.

Costs paid for or not charged by the Clinical Trial Providers are not Covered.

Care for Military Service Connected Disabilities

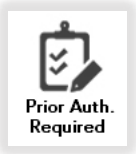
Care for military service connected disabilities to which you are legally entitled and for which facilities are reasonably available to you is not Covered.

Certified Hospice Care Benefits

Certified Hospice Care Benefits are not Covered for the following services:

- Food, housing, and delivered meals are not Covered.
- Volunteer services are not Covered.
- Personal or comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits) are not Covered.
- Homemaker and housekeeping services are not Covered.
- Private duty nursing is not Covered.
- Pastoral and spiritual counseling are not Covered.
- Bereavement counseling is not Covered.

- The following services are not Covered under Hospice care, but may be **Covered Benefits elsewhere in this Agreement** subject to the Cost Sharing requirements:
    - Acute Inpatient Hospital care for curative services – requires **Prior Authorization**
    - Durable Medical Equipment
    - Practitioner/Provider visits by other than a Certified Hospice Practitioner/Provider
    - Ambulance Services



Charges in Excess of Medicare Allowable Unreasonable

Charges that we determine to be in excess of Medicare Allowable Charges and charges we determine to be unreasonable are not Covered.

Clothing or Other Protective Devices

Clothing or other protective devices, including prescribed photo-protective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not, are not Covered.

Clinical Preventive Health Services

Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to employment are not Covered.

Immunizations for the purpose of foreign travel are not Covered.

Complementary Therapies

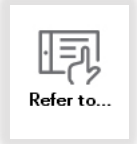
Complementary Therapies, except those specified in the **Complementary Therapies Benefits Section**, are not Covered.

- **Acupuncture** – Except as specified under Complementary Therapies in the Benefits Section.
- **Chiropractic Services** – Except as specified under Complementary Therapies in the Benefits Section.
- **Biofeedback** – Except as specified under Complementary Therapies in the Benefits Section.

Cosmetic Surgery

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

This plan does not cover cosmetic surgery, services, or procedures to change family characteristics or conditions caused by aging. This plan excludes coverage for cosmetic surgery or services for psychiatric or psychological reasons unrelated to care for gender dysphoria and medically necessary gender confirmation care. This plan does not cover services related to or required as a result of a cosmetic service, procedure, surgery or subsequent procedures to correct unsatisfactory Cosmetic results attained during an initial surgery.



Circumcisions, performed other than for newborns, are not Covered unless Medically Necessary.

Reconstructive Surgery following a mastectomy is not considered Cosmetic Surgery and will be covered. Refer to the **Benefits Section**.

Cosmetic Treatments, Devices, Orthotics, and Prescription Drugs/Medications

Cosmetic treatment, devices, Orthotics and Prescription Drugs/Medications are not Covered.

Costs for Extended Warranties and Premiums for Other Insurance Coverage

Costs for extended warranties and premiums for other insurance coverage are not Covered.

Dental Services

Dental care and dental X-rays are not Covered, except as provided in the Benefits Section.

Dental implants are not Covered.

Malocclusion treatment, if part of routine dental care and orthodontics, is not Covered.

Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are not Covered, unless the disorder is trauma related.

Diabetes Services

Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, is not Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids

Durable Medical Equipment

Upgraded or deluxe Durable Medical Equipment is not Covered.

Convenience items are not Covered. These include, but are not limited to, an appliance, device, object or service that is for comfort and ease and is not primarily medical in nature, such as, shower or tub stools/chairs, seats, bath grab bars, shower heads, hot tubs/Jacuzzis, vaporizers, accessories such as baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those Covered under Durable Medical Equipment Benefits).

Duplicate Durable Medical Equipment items (i.e., for home and office) are not Covered.

Repair and Replacement

Repair or replacement of Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience is not Covered.

Repair and replacement of items under the manufacturer or supplier’s warranty are not Covered.

Additional wheelchairs are not Covered, if the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair.

Orthotic Appliances

Functional foot Orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints are not Covered, except for patients with diabetes or other significant peripheral neuropathies.

Custom-fitted Orthotics/Orthosis are not Covered except for knee-ankle-foot (KAFO) Orthosis and/or ankle-foot Orthosis (AFO) except for Members who meet national recognized guidelines.

Prosthetic Devices

Artificial aids including speech synthesis devices are not Covered, except items identified as being Covered in the Benefits Section.

Surgical Dressing

Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, adhesive bandages, gauze (such as 4 by 4's), and elastic wrap bandages are not Covered, except when provided in a Hospital or Practitioner's/Provider's office or by a home health professional.

Gloves are not Covered, unless part of a wound treatment kit.

Elastic Support hose are not Covered.

Eyeglasses and Contact Lenses

Routine vision care and Eye Refractions for determining prescriptions for corrective lenses are not Covered, except as identified in the **Benefits Section**.

Corrective eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, are not Covered except as identified in the **Benefits Section**.

Eye refractive procedures including radial keratotomy, laser procedures, and other techniques are not Covered.

Visual training is not Covered.

Eye movement therapy is not Covered.

Exercise Equipment, Personal Trainers

Exercise equipment, videos, personal trainers, and weight reduction programs are not Covered.

Experimental or Investigational drugs, Diagnostic Genetic Testing, Medicines, Treatments, Procedures, or Devices

Experimental or **Investigational** drugs, diagnostic genetic testing, medicines, treatments, procedures, or devices are not Covered.

Experimental or Investigational medical, surgical, diagnostic genetic testing, other healthcare procedures or treatments, including drugs. As used in this Agreement, "Experimental" or "Investigational" as related to drugs, devices, medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by state law, the drug or device is used for a purpose that is not approved by the FDA; or
- Testing is Covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient and if approved by the FDA. Routine genetic testing is not Covered; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in state law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

Extracorporeal Shock Wave Therapy

Extracorporeal shock wave therapy involving the musculoskeletal system is not Covered.

Foot Care

Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, is not Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.

Genetic Testing

Genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Accordingly, a test to determine whether an individual has BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. The results of a genetic test can confirm or rule

out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder. Genetic testing is not covered when the test is performed primarily for the medical management of other family members. Additional expenses for banking of genetic material is not covered.

Genetic Inborn Errors of Metabolism Coverage

Genetic Inborn Errors of Metabolism Coverage does not include the following items:

- Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other Over-the-counter (OTC) digestive aids are not Covered, unless listed as a Covered Over-the-counter (OTC) medication on our *Formulary*.
- Ordinary food that might be part of an exclusionary diet are not Covered.
- Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM are not Covered.
- Special Medical Foods for conditions that are not present at birth are not Covered.
- Dietary supplements and items for conditions including, but not limited to, Diabetes Mellitus, Hypertension, Hyperlipidemia, Obesity, Autism Spectrum Disorder, Celiac Disease and Allergies to food products are not Covered.

Hair-loss (or baldness)

Hair-loss or baldness treatments, medications, supplies and devices, including wigs, and special brushes are not Covered regardless of the medical cause of the hair-loss or baldness.

Home Health Care Services/Home Intravenous Services and Supplies

Private duty nursing is not Covered.

Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for Home Health Care Services and are not Covered. Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

Hospital Services

Rehabilitation is not Covered as part of acute medical detoxification.

Mental Health and Alcohol and Substance Use Disorder

Mental Health

- Codependency treatment is not Covered.
- Bereavement, pastoral/spiritual and sexual counseling are not Covered.

- Psychological testing when not Medically Necessary is not Covered.
- Special education, school testing or evaluations, educational counseling, therapy or care for learning deficiencies or disciplinary problems are not Covered. This applies whether or not associated with manifest mental illness or other disturbances except as Covered under the Family, Infant and Toddler Program. Refer to the **Benefits Section**.
- Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy is not Covered.
- Alcohol and/or Substance Use Disorder services are not considered mental health benefits.

Alcoholism Services and Substance Use Disorder Services

- Treatment in a halfway house is not Covered.
- Codependency treatment is not Covered.
- Bereavement, pastoral/spiritual and sexual counseling are not Covered.

Nutritional Support and Supplements

Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings is not Covered.

Out-of-State Surcharges

Out-of-state surcharges are not Covered

Palliative Care

Palliative care may be appropriate at any age and at any stage in a serious illness, and it can be provided together with curative treatment. Palliative care is not Covered under this plan.

Practitioner/Provider Services

Services provided by an Excluded Provider are not Covered. Any benefit or service, including pharmaceuticals, provided by an Excluded Provider as defined and maintained by the following regulatory agencies: Department of Health and Human Services; Office of the Inspector General (OIG); U.S. Department of Health; the General Services Administration; and the Office of Personnel Management, Office of Inspector General, which includes, but is not limited to, the:

- Excluded Parties Lists System (EPLS),
- List of Excluded Individuals/Entities (LEIE),
- Office of Personnel Management (OPM).

Office Visits, listed below, are not Covered.

- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided are not Covered.

Infertility services, listed below, are not Covered.

- Prescription Drugs Oral and Injectable when provided by a practitioner/provider
- Reversal of voluntary sterilization is not Covered.
- Donor sperm is not Covered.
- In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization are not Covered.
- Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue is not Covered.

Prescription Drugs/Medications

- Prescription Drugs/Medications that require a **Prior Authorization** when **Prior Authorization** was not obtained may not be 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 when Medical Necessity has not been established 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, unless Medical Necessity has been met.
- 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 and non-FDA approved hormone pellets are Not Covered.
- Local Delivery of Antimicrobial Agents (LDAA) used for Periodontal Procedures are Not Covered.

Radiation

Any claim directly or indirectly caused by or contributed to or arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel, the radioactive toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof is not Covered.

Reconstructive Surgery for Cosmetic Purposes

Reconstructive Surgery for Cosmetic purposes is not Covered unless reconstruction is performed after a mastectomy.

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

Reconstructive surgery regarding the breast and chest region related to Gender Confirmatory Therapy and Gender Affirming Care is a Covered benefit. The **Prior Authorization** criteria of this Plan is applicable.

Rehabilitation and Therapy

Rehabilitation and Therapy, as listed below, is not Covered.

Short or Long-term Rehabilitation services listed are not Covered:

- Athletic trainers or treatments delivered by Athletic trainers are not Covered.
- Vocational Rehabilitation Services are not Covered.
- Long-term Therapy or Rehabilitation Services are not Covered. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when:
    - You have reached maximum rehabilitation potential.
    - You have reached a point where Significant Improvement is unlikely to occur.
    - You have had therapy for four consecutive months.
    - 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. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, Cerebral Palsy, and Developmental Delays not associated with a defined event of illness or injury.
- Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome, and Cerebral Palsy.

Speech Therapy services listed below are not Covered:

- Therapy for stuttering is not Covered.
- Voice Training is not Covered.
- Hearing Aids and the evaluation for the fitting of Hearing Aids are not Covered, except for school aged children under **18 years** old (or under **21 years** of age if still attending high school).
- Additional benefits beyond those listed in the **Speech Therapy Benefit Section** are not Covered.

Services for Which You or Your Dependent are Eligible under Any Governmental Program

Services for which you or your Dependent are eligible under any governmental program (except Medicaid), to the extent determined by law, are not Covered. Services for which, in the absence of any health service plan or insurance plan, no charge would be made to you or your Dependent, are not Covered.

Services Requiring Prior Authorization When Out-of-network (outside of the 5-county area)

If you fail to obtain **Prior Authorization** for services received Out-of-network (outside of the 5-county area) that require **Prior Authorization**, those services are not Covered. However,

Members are not liable when an In-network Practitioner/Provider does not obtain **Prior Authorization**. Refer to **Prior Authorization Section** for specific information.

Sexual Dysfunction Treatment

Treatment for sexual dysfunction, including medication, counseling, and clinics, are not Covered, except for penile prosthesis as listed in the **Benefits Section**.

Skilled Nursing Facility Care

Custodial or Domiciliary care is not Covered.

Smoking Cessation Services

Smoking Cessation services listed below are not Covered:

- Hypnotherapy for Smoking Cessation Counseling is not Covered,
- Over-the-counter (OTC) drugs are not Covered, unless listed as a Covered Over-the-counter (OTC) medication on our *Formulary*.
- Acupuncture for Smoking Cessation Counseling is not Covered.

Thermography

Thermography Services are not Covered.

Transplant Services

Transplant Services listed below are not Covered:

- Non-human Organ transplants, except for porcine (pig) heart valve, are not Covered.
- Transportation costs for deceased Members are not Covered.
- The medical and Hospital services of an Organ transplant donor (i.e. living donor) when the recipient of an Organ transplant is not a Member or when the transplant procedure is not a Covered Benefit are not Covered.
- Travel and lodging expenses are not Covered except as provided in the Benefits Section.

Treatment While Incarcerated

Services or supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison are not Covered.

War

Any claim directly or indirectly occasioned by, happening through, or in consequence of war, acts of foreign enemies, hostilities (whether war be declared), acts of terrorism, civil war,

rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition or destruction of or damage to property by or under the order of government or public or local authority is not Covered.

Women's Healthcare

Elective abortions after the 24th week of pregnancy are not Covered.

Maternity and newborn care, as follows, are not Covered:

- Use of an emergency facility for non-emergent services is not Covered.
- Elective Home Birth and any prenatal or postpartum services connected with an Elective Home Birth are not Covered. Allowable sites for a delivery of a child are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

Work-related Illnesses or Injuries

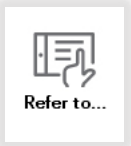
Work-related illnesses or injuries are not Covered, even if:

- 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 Worker's Compensation Insurance.
- You fail to comply with any other provisions of the law.

Claims

Your healthcare benefits are considered and paid according to the conditions outlined in this Section. If you paid a Provider for services, this Section outlines the process to follow for reimbursement.

When services are obtained from an In-network Practitioner/Provider, the Practitioner/Provider will submit the claim to Presbyterian for you. It is important that you provide your current Presbyterian identification card to the Practitioner/Provider so they may obtain the mailing address listed on the back of the card. Services obtained from In-network Practitioners/Providers may require Cost Sharing amounts (Copayments, Deductible and/or Coinsurance) that you pay at the time of service. The amount of your Cost Sharing responsibility for each service can be found in your *Summary of Benefits and Coverage*.



Notice of Claim

The timely filing limit for an In-network Practitioner/Provider is **90 days** from the date of service, whereas the timely filing limit for an Out-of-network (outside of the 5-county area) Practitioner/Provider is **1 year** from the date of service.

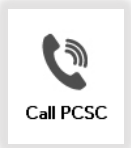
Written notice of claim must be given to us within **20 days** after the date of loss or as soon as reasonably possible. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

You may call or write to us to notify us of a claim. Presbyterian Health Plan, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within **15 days** after the giving of such notice the Member shall be deemed to have complied with the requirements of this policy as to the proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. You may access our website, **https://www.phs.org/healthplans/member-information/Pages/forms-and-documents.aspx** to obtain a claim form.

In-network Practitioners/Providers

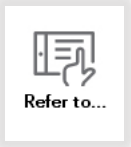
We reimburse In-network Practitioners/Providers for Covered services provided to you. You should not be required to pay sums to any In-network Practitioner/Provider, except for the required cost sharing amount. You will be responsible for the payment of fees charged for missed appointments or appointments canceled without adequate notice, if any.



If you are asked by an In-network Practitioner/Provider to make any payments in addition to the Cost Sharing amount specified in this Agreement, you should consult our Presbyterian Customer Service Center at **(505) 923-7521 or 1-855-923-7521**, Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711** before making any such additional payments. You will not be liable to an In-network Practitioner/Provider for any sums that we owe the Practitioner/Provider. Presbyterian does not discriminate against any health care provider who is acting within the scope of their license or certification under applicable State law.

Out-of-network (outside of the 5-county area) Practitioners/Providers

Except for Emergency Healthcare Services described in the **Accidental Injury / Urgent Care / Emergency Health Services / Observation / Trauma Services Benefit Section**, you must receive our written **Prior Authorization** prior to receiving services from an Out-of-network (outside of the 5-county area) Practitioner/Provider. Otherwise, you may be responsible for all charges incurred.



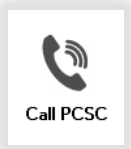
If you are Authorized to obtain services from an approved Out-of-network (outside of the 5-county area) Practitioner/Provider, as specified in the **Prior Authorization Section**, you may be required to make full payment to that Out-of-network (outside of the 5-county area) Practitioner/Provider at the time services are rendered. You should then submit the claim or a summary of the medical services rendered, in addition to Proof of Payment. Proof of payment includes a copy of the endorsed check, credit card statement or receipt showing that the services were paid in full satisfactory evidence to us that such payment was made to an Out-of-network (outside of the 5-county area) Practitioner/Provider. Upon review and approval of the evidence of payment and **Prior Authorization**, we shall reimburse you for Covered Benefits, based upon Medicare Allowable Charges, less any required Copayment and/or Coinsurance you would have been required to pay if the services had been obtained from an In-network Practitioner/Provider. **You will be responsible for charges not specifically Covered by us.**

Emergency Healthcare Services rendered to a Member while traveling outside of the 5-county area shall be Covered as specified in the **Accidental Injury/ Urgent Care/Emergency Health Services/Observation/Trauma Services Benefits Section** of this Agreement.

Procedure for Reimbursement

When you receive Covered Services from a Practitioner/Provider and the Practitioner/Provider charged for that service, written proof (claim) of such charge must be furnished to us within **90 days** from the date of service for In-network Practitioners/Providers and within **1year** from the date of service for Out-of-network (outside of the 5-county area) Practitioners/Providers in order for you to receive reimbursement. If you are relying on an Out-of-network (outside of the 5-county area) Practitioner/Provider to furnish a claim on your behalf, you are responsible for ensuring claims have been submitted within **1 year** from the date of service. Any such charge

shall be paid upon our receipt of a Practitioner/Provider billing or completed valid claim for the Healthcare Services for which claim is made.



If you need a claim form or have questions regarding a charge made by your Practitioner/Provider, please contact our Presbyterian Customer Service Center at **(505) 923-7521 or 1-855-923-7521**, Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Claim forms are also available on our website at **www.phs.org**.

Please submit your completed claim form to:

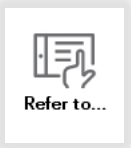
Presbyterian Health Plan
Attn: Claims
P.O. Box 27489
Albuquerque, NM 87125-7489

Services Received Outside the United States

Benefits are available for Emergency Healthcare Services and Urgent Care services received outside the United States. These services are Covered as explained in the **Benefits Section**. You are responsible for ensuring that claims sent to us, at the address cited above, are appropriately translated and that the monetary exchange rate effective on the date(s) you received medical care is clearly identified when submitting claims for services received outside the United States.

Presbyterian cannot reimburse foreign Practitioners/Providers. You should then submit the claim or a summary of the medical services rendered, in addition to Proof of Payment. Proof of payment includes a copy of the endorsed check, credit card statement or receipt showing that the services were paid in full.

Claim Fraud



Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate your Coverage for any type of fraudulent activity. For further information regarding Fraud, refer to the **General Provisions Section**.

Effects of Other Coverage

This Section explains how we will coordinate benefits should you have medical coverage through another Health Benefits Plan.

Coordination of Benefits

If you have medical coverage under any other Health Benefits Plan, other public or private group programs, or any other health insurance policy, the benefits provided or payable hereunder shall be reduced to the extent that benefits are available to you under such other plan, policy or program.

Coordination of Benefits (COB) applies to this Agreement when a Member has medical benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual medical bills. PHP coordinates benefits according to the "Standard Other Insurance Rule". Please contact the Presbyterian Customer Service Center for additional information on this rule. Also, each plan determines the maximum allowable payment for a given service and this maximum allowable may vary by plan. For this reason, there is no guarantee that 100 percent (**100%**) of the charges will be paid even when a Member has more than one medical plan.

The rules establishing the order of benefit determination between this Agreement and any other plan covering a Member not on COBRA continuation on whose behalf a claim is made are as follows:

- Employee/Dependent Rule
    - The plan, which covers you as an employee, pays first.
    - The plan, which covers you as a Dependent, pays second.
- Birthday Rule for Dependent children of parents who are not separated or divorced
    - The plan, which covers the parent whose birthday falls earlier in the year, pays first. The plan, which covers the parent whose birthday falls later in the year, pays second. The birthday order is determined by the month and the day of birth, not the year of birth.
    - If both parents have the same month and day of birth, the plan that Covered the parent longer, will pay claims first. The plan which covered the parent for a shorter period of time pays second.
- Dependent children of separated or divorced parents
    - The plan of the parent decreed by a court of law to have responsibility for medical coverage pays first.
    - In the absence of a court order:
        - The plan of the parent with physical custody of the child pays first.
        - The plan of the Spouse of the parent with physical custody (i.e., the stepparent) pays second.
        - The plan of the parent not having physical custody of the child pays third.

- Active/Inactive Employee
    - The plan, which covers you as an active employee (or Dependent of an active employee), pays first.
    - The plan, which covers you as a retired or laid-off employee (or Dependent of a retired or laid-off employee), pays second.
- Longer/Shorter Employment
    - In the case where you are the Subscriber under more than one group health insurance policy, then the plan that has Covered you for a longer period of time will pay first. A change of insurance carrier by the group employer does not constitute the start of a new plan.
- No Coordination Provision
    - In spite of the rules listed above, the plan that has no provision regarding coordination of benefits will pay first.
- If you are covered under a motor vehicle or homeowner's insurance policy which provides benefits for medical expenses resulting from a motor vehicle accident or accident in your own home, you shall not be entitled to benefits under this Agreement for injuries arising out of such accident to the extent they are covered by the motor vehicle or home owner's insurance policy. If we have provided such benefits, we shall have the right to recover any benefits we have provided from you or from the motor vehicle or homeowner's insurance to the extent they are available under the motor vehicle or homeowner's insurance policy.
- If you or your Dependents are Covered by COBRA continuation and are also Covered by another group plan, you shall receive our Covered Benefits to the extent that we will be secondary payer of all eligible charges, subject to the terms, conditions**, exclusions and limitations** of this Agreement.

In no event shall the Covered Benefits received under this Agreement and all other plans combined exceed the total reasonable actual expenses for the services provided under this Agreement.

For purposes of coordination of benefits,

- We may release, request, or obtain claim information from any individual or 0o1rganization. In addition, any Member claiming benefits from us shall furnish us with any information which we may require.
- We have the right, if we make overpayments because of your failure to report other coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made.
- We will not be obligated to pay for non-Covered Services or Covered Benefits not obtained in compliance with our policies and procedures.
- To the extent necessary for PHP to meet its obligations as a secondary carrier under NM regulations, PHP shall make payments for services that are received from non-participating providers, provided outside the service area, or that are covered under the terms of the contract or evidence of coverage.

Medicare

If you are enrolled in Medicare, the Covered Benefits provided by this Agreement are not designed to duplicate any benefit to which you are entitled under the Social Security Act. Covered Benefits will be coordinated in compliance with current applicable federal regulations.

Medicaid

The Covered Benefits payable by us under this Agreement, on behalf of a Member who is qualified for Medicaid, will be paid to the state Human Services Department, or its designee, when:

- The Human Services Department has paid or is paying benefits on behalf of the Member under the state's Medicaid program pursuant to Title XIX and/or Title XXI of the Federal Social Security Act.
- The payment for the services in question has been made by the state Human Services Department to the Medicaid Practitioner/Provider.

Subrogation (Recovering Healthcare Expenses from Others)

The Covered Benefits under this Agreement will be available to you if you are injured by the act or omission of another person, firm, operation or entity. If you receive Covered Benefits under this Agreement for treatment of such injuries, we will be subrogated to your rights or the Personal Representative of a deceased Member, or Dependent Member, to the extent of all such payments made by us for such benefits. This means that if we provide or pay Covered Benefits, you must repay us the amounts recovered for all such payments made by us in any lawsuit, settlement, or by any other means. This rule applies to any and all monies you 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.

By way of illustration only, our right of subrogation includes, but is not limited to, the right to be repaid when you recover money for personal injury sustained in a car accident. The subrogation right applies whether you recover directly from the wrongdoer or from the wrongdoer’s insurer, or from your uninsured motorist insurance coverage. You agree to sign and deliver to us such documents and papers as may be necessary to protect our subrogation right. You also agree to keep us advised of:

- Any claims or lawsuits made against any person, firm or entity responsible for any injuries for which we have paid Covered Benefits.
- Any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.

Settlement of a legal claim or controversy without prior notice to us is a violation of this Agreement. In the event you fail to cooperate with us or take any other action, through agents or

otherwise, which interferes with the exercise of our subrogation right, we may have, and hereby expressly reserve, all legal remedies available to us.

When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both you and us, we will, upon request by you or your attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if we receive appropriate documentation of such collection costs and legal expenses.

Summary of Health Insurance Grievance Procedures

This Section explains how to file a Complaint, Grievance and Appeal.

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau** page found under the **Departments** tab on the Office of Superintendent of Insurance (OSI) website, located at **www.osi.state.nm.us**. You may also request a copy from your insurer at: **www.phs.org** or from OSI by calling **(505) 827-4601** or toll free at **1-833-415-0566**.

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse determination: You may request a review if your insurer has denied preauthorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (The insurer must notify you before terminating or reducing coverage for an ongoing course of treatment and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by the insurer of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called "adverse determinations."

Administrative decision: You may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of healthcare services; claims payment, handling or reimbursement for healthcare services; or if your coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a healthcare service work?

When your insurer receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

- **Coverage:** First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

- **Medical necessity:** Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, the insurer might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, your insurer might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, the insurer may deny certification. Your insurer might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. However, you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: The insurer must make an initial decision within **5 working days**. However, the insurer may extend the review period for a maximum of **10 calendar days** if it: **(1)** can demonstrate reasonable cause beyond its control for the delay; **(2)** can demonstrate that the delay will not result in increased medical risk to you; and **(3)** provides a written progress report and explanation for the delay to you and your provider within the original **5 working day** review period.

What if I need services in a hurry?

Urgent care situation: An urgent care situation is a situation in which a decision from the insurer is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** the physician with knowledge of your medical condition **reasonably** requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an urgent care situation or your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either certify or deny the

initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within **24 hours** after receiving the request for an **expedited** decision.

If you are dissatisfied with the insurer's initial expedited decision in an urgent care situation, you may then request an **expedited review** of the insurer's decision by both the insurer and an external reviewer called an Independent Review Organization (IRO). When an expedited review is requested, the insurer must review its prior decision and respond to your request within 7**2 hours**. If you request that an IRO perform an **expedited review** simultaneously with the insurer's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within **72 hours** after receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within **72 hours** after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?

If the initial request is approved, the insurer must notify you and your provider within **1 working day** after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the provider within **24 hours** after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Phone: (505) 923-7521 or at 1-855-923-7521
Address: Presbyterian Health Plan
Attn: Appeals and Grievance Department
P.O. Box 27489
Albuquerque, NM 87125-7489

Fax: (505) 923-6111
Email: **gappeals@phs.org**

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:

Phone: (505) 827-4601 or toll free at 1-**833-415-0566**
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
Fax: (505) 827-4734, Attn: MHCB
Email: **mhcb.grievance@state.nm.us**

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review

If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, the insurer will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review: If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than **72 hours** from the time the internal review request was received.

Standard review: Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within **30 days** after receipt of your pre-service request for review or within **60 days** if you have already received the service. The medical director's review generally takes only a few days.

The medical director denied my request - now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent. If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider and ask questions of the panel members. Your health provider may also address the panel or send a written statement.

If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may **NOT** request an IRO review if you skip the panel review.

How long do I have to make my decision?

If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that the insurer provide a panel to review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone or arrange to have someone attend with you or on

your behalf. You may review all of the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.

The insurer's internal panel must complete its review within **30 days** following your original request for an internal review of a request for pre-certification or within **60 days** following your original request if you have already received the services. You will be notified within **1 day** after the panel decision. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of **30 days**.

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months** to request a review by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the insurer or with you. The reviewer will consider all of the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must provide them.

The IRO's fees are billed directly to the insurer – there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within **20 days** after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within **72 hours** after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within **30 days** after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within **180 days** after the date you are notified of the decision. The insurer will notify you within **3 days** after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The insurer will mail a decision to you within **30 days** after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have **20 days** to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within **15 days** after the insurer receives your request. You will be notified at least **5 days** prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to **30 days**.

The reconsideration committee will mail its decision to you within **7 days** after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at **www.osi.state.nm.us**. You may also call OSI to request the forms at **(505) 827-4601** or toll free at **1-833-415-0566**.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has **5 days** to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within **45 days**. If you need extra time to gather information, you may request an extension of up to **90 days**. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal healthcare records and/or genetic information must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of the Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

Records

Your medical records are important documents needed in order to administer your Health Benefits Plan. This Section explains how we ensure the confidentiality of these records and how these records are used to administer your plan.

Creation of Non-Medical Records

We shall keep your records related to personal identification information, which does not specifically relate to your medical diagnosis or treatment. You shall forward information periodically to us as we may require in connection with the administration of this Agreement.

Accuracy of Information

We shall not be liable to fulfill any obligation which is dependent upon information submitted by you prior to its receipt in a satisfactory manner. We are entitled to rely on such information as submitted. We at our sole discretion may make any necessary corrections due to recognizable clerical error. We will date and initial the correction of the error.

Consent for Use and Disclosure of Medical Records

We are entitled to receive from any Practitioner/Provider of services Protected Health Information (PHI) about you to the extent permitted by applicable law, for any permitted purpose, including but not limited to, quality assurance, Utilization Review, processing of claims, financial audits or other purposes related to payment and certain of our healthcare operation activities. A determination of benefit Coverage may be suspended pending receipt of this information. By acceptance of Coverage under this Agreement, you give consent to each Practitioner/Provider rendering services hereunder to disclose all information to us (to the extent permitted by applicable law) pertaining to you for any permitted purpose specified in the law. This consent shall not permit a use or disclosure of PHI when an authorization is required by law or when another condition must be met for such use or disclosure to be permitted under applicable law. We will comply with the Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

Professional Review

We are permitted by law to use your records to conduct professional/regulatory review programs for Healthcare Services without your consent/authorization. Such review programs include, but are not limited to, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and the Office of the Superintendent of Insurance (OSI).

Confidentiality of Protected Health Information/Medical Records

You will receive a Notice of Privacy Practices that we issue, which will contain a statement of your rights with respect to PHI and a brief description of how you may exercise your rights.

What is PHI?

Protected Health Information, or PHI, is any health information about you that clearly identifies you or that could reasonably be used to identify you and your health needs that we send, receive, or keep as part of our daily work to improve your health. This includes information sent, received, and kept by electronic, written and oral means. Medical records and claims are two examples of PHI.

We keep your PHI safe. Unless otherwise permitted or required by law, we will not disclose confidential information without your consent/authorization. Your privacy in all settings is important to us.

As a Member you (or your legal guardian/Personal Representative) have the right to:

- Request restrictions on certain uses and disclosures of PHI, although we are not required to agree to a requested restriction.
- Receive confidential communications of PHI from us.
- With certain exceptions, inspect and receive a copy of PHI.
- Request an amendment to PHI you believe to be incorrect or incomplete.
- Receive an accounting of certain disclosures of PHI.
- Obtain a paper copy of the Notice of Privacy Practices from us upon request (even if you previously agreed to receive the Notice(s) electronically).

Access to PHI

All confidential documents are kept in a physically secure location with access limited to authorized Plan personnel only. You (or your legal guardian/Personal Representative) have the right, with certain exceptions, to request access to inspect and obtain a copy of your PHI. We may charge a reasonable fee for providing a copy, summary or explanation of the information you request. If there is a fee, we will tell you how much it will cost before we provide the requested information. You may change your request to avoid or reduce the fee.

You do not have the right to inspect or obtain a copy of PHI that consists of:

- Psychotherapy notes
- Information gathered in reasonable expectation of, or for use in, a civil, criminal, or Administrative action or proceeding
- PHI maintained by us that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to you

would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2).

To request access to inspect or obtain a copy of your PHI, you must submit your request in writing to:

Presbyterian Health Plan
Attn: Director, Presbyterian Customer Service Center
P.O. Box 27489
Albuquerque, NM 87125-7489

We will act on your request for access to PHI no later than **30 days** after receipt of the request. If we are unable to take an action within the required timeframe, the Plan may take up to **30 additional days,** provided that, no later than **30 days** after receiving your request, the Plan provides you with a written statement of the reason for the delay and date by which we will complete its action on your request.

Routine Uses and Disclosures of PHI

We routinely use PHI for a number of important and appropriate purposes, including:

- Claims payment
- Fraud and abuse prevention
- Data collection
- Performance measurements
- Meeting state and federal requirements
- Utilization management
- Accreditation activities
- Preventive health services
- Early detection and disease management programs
- Coordination of care
- Quality assessment and measurement, including surveys, research of Complaints and Grievances, billing and other stated uses
- Responding to your requests for information, products or services

We do not disclose PHI to anyone other than as permitted by the plan documents or required by law. We use and disclose information we collect only as necessary to deliver healthcare products and services to you in accordance with our Contracts, or to comply with legal requirements.

Our employees refer to your Personal Health Information only when necessary to perform assigned duties for their job. Our employees handle your health records according to our stringent confidentiality policies.

Consents/Authorizations

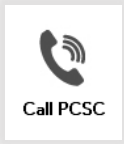
Although consent from you (or your legal guardian/Personal Representative) is not required to use or disclose PHI for certain purposes specified in the law, a Practitioner/Provider shall request that you (or your legal guardian/Personal Representative) sign a consent form permitting disclosure of medical records (to the extent permitted by law) to us at the time of your first visit to the Practitioner/Provider.

In the event that the Practitioner/Provider fails to obtain such consent for disclosure to us, or you refuse to sign such consent for disclosure to us, we shall use our best efforts to obtain such written consent from you (or your legal guardian/Personal Representative) prior to the Practitioner's/Provider's release of PHI (i.e., health records) to us for purposes permitted by law.

When you sign your enrollment form (Application), you are giving consent (to the extent permitted by applicable law) to the use or the release of your PHI by any person or entity including without limitation, Practitioners/Providers and insurance companies, to us or our designees (including its authorized agents, regulatory agencies and affiliates) for any permitted purpose, including but not limited to, quality assurance, Utilization Review, processing of claims, financial audits or other purposes related to the payment, or certain healthcare operations activities of our Plan. This consent does not permit a use or disclosure of PHI when an authorization is required by law.

We will not further release PHI about you without your permission/authorization unless permitted or required by law.

We require all In-network Practitioners/Providers and facilities to maintain confidential patient information in accordance with federal and state laws including, HIV/AIDS status, mental health, sexually transmitted infections or alcohol/drug use. State and federal law prohibits further disclosure of HIV/AIDS, other sexually transmitted infection, mental health and alcohol and/or drug use disorder information to any person or agency without obtaining specific valid written authorization for that purpose from the patient (or legal guardian/Personal Representative), or as otherwise permitted by state or federal law.



To request an Authorization Form, please contact our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**. Authorization Forms will be kept in your medical record or enrollment file.

Members Who Are Unable to Give Consent/Authorization

Sometimes courts or doctors decide that certain people are unable to understand enough to make decisions for themselves. Usually, a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health information rights described herein for the child or other person, but not always. Unless

otherwise required or permitted by law, when we need an Authorization Form signed for a person who can't make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

Right to Request Amendments (Changes) to PHI

We recognize your right to request amendment of PHI or a record containing PHI for as long as the PHI is maintained in our records. Our Presbyterian Customer Service Center will accept written requests to amend PHI. We must approve or deny your request to amend the disputed PHI no later than **60 days** after receipt of the request. If we are unable to take an action within the required timeframe, we may take up to **30 additional days**, provided that, no later **than 60 days** after receiving your request, we provide you with a written statement of the reason for the delay and date by which we will complete our action on your request and notify you in writing of the determination no later than **60 to 90 days** after receipt of such a request.

Process for Members to Request an Accounting of Disclosures of PHI

You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center by calling Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.

Restriction of PHI Use or Disclosures

You (or your legal guardian/Personal Representative) have the right to request that use or disclosure of your PHI be restricted for the following purposes:

- Our treatment, payment and healthcare operations
- To persons involved in your care (i.e., family member, other relative, close personal friend, or any other person identified by you)
- For notification purposes of your location, general condition, or death
- To a public or private entity authorized by law or its charter to assist in disaster relief efforts

We are not required by law to agree to any requested restriction. If we agree to honor a requested restriction, we will not violate such restriction, except as permitted by law. We will accept your written request to restrict the use or disclosure of your PHI or will document your verbal request in our records.

Use of Measurement Data

It is important for us to know about your illnesses to help us improve the quality of care our healthcare Practitioners/Providers provide to you. We sometimes use medical data (laboratory results, diagnoses, etc.) which does not identify you for this purpose.

Internal Protection of Oral, Written and Electronic PHI Across PHP

To ensure internal protection of oral, written, and electronic PHI across our organization, the following rules are strictly adhered to:

- PHI is accessed by Plan personnel only if such information is necessary to the performance of job-related tasks.
- PHI is not discussed inside or outside our facility unless the data is necessary to the performance of job-related tasks.
- PHI reports and other written materials are reasonably safeguarded throughout the facility against unauthorized access by Plan personnel or public viewing.
- All employees, volunteers, and any external entity with a business relationship with us that involves health information will be held responsible for the proper handling of our data and business communications and are required to sign a confidentiality statement or business associate agreement, respectively.

Violation of the above rules by any member of our workforce is grounds for disciplinary action, up to and including immediate dismissal.

Website Internet Information

We enforce security measures to protect PHI that is maintained on the website, network, software, and applications. We collect two types of information from visitors to our website:

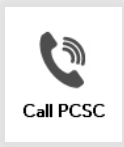
- Website traffic statistics, including:
    - Where visitor traffic comes from
    - How traffic flows within the website
    - Browser type

  We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful.

- Personal information that you provide to us (such as your name, address, billing information, Health Benefit Plan enrollment status, etc.) if you fill out a form on our website.
    - We use your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries.
    - We do not sell, trade, or rent personal information provided by visitors to our website to other persons, companies or partners.

Protection of Information Disclosed to Plan Sponsors, Employers or Government Agencies

Our policies and procedures prohibit sharing your PHI with any fully insured employer Group's plan sponsor without your (or your legal guardian/Personal Representative's) authorization. We are careful not to release PHI to your employer as part of routine financial and operating reports. We may disclose summary health information that does not identify you to plan sponsors for allowable purposes. We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards as permitted by law.



If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center, Monday through Friday, from 7 a.m. to 6 p.m. at **(505) 923-7521 or 1-855-923-7521**. Hearing impaired users may call **TTY 711** or visit our website at **www.phs.org**.

Eligibility, Enrollment, Effective Dates, Termination and Continuation

This Section explains eligibility requirements for Subscribers and/or their Dependents, important effective dates, conditions for Termination of Coverage and continuing Coverage for Members who become ineligible for this plan.

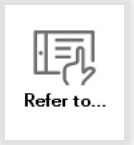
How You Can Enroll as a Member

To be eligible for Covered Benefits in accordance with the terms of this Agreement, you must be enrolled as a Member. To be eligible to enroll as a Member, you must be a Subscriber or a Dependent of the Subscriber and meet the criteria listed below.

Eligible Subscribers

A Subscriber is the person whose employment with the Employer (Group) or other status is the basis for enrollment eligibility. To be eligible to enroll as a Subscriber, you must:

- Be an active permanent full-time employee of the Group who is currently working the minimum number of hours specified in the Group Letter of Agreement (GLA) and has completed the required probationary period and the required waiting period.
    - Waiting periods are established by the employer upon application for the group and are determined at the sole discretion of the employer, not to exceed 90 days from the date of hire
- Physically live or work in the 5-county area, our Service Area.
- Continue to meet your Group specific enrollment and eligibility requirements as outlined in the GLA.



A Subscriber who has had a prior Contract or Agreement with us terminated for Good Cause, as described in the **Glossary of Terms** section or under any similar Sections of our other Agreements, is not eligible to enroll.

To learn about eligibility criteria required by your Group, you may contact your Group's benefits administrator.

You must provide proof that you meet the **eligibility requirements** required by your Group and as stated in your Application.

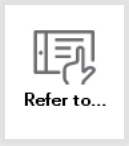
Eligible Dependents

A Dependent is a family member of a Subscriber as described in this Section. To be eligible to enroll as a Dependent for Coverage and become a Member, your Dependent must be:

- Your legally married Spouse (of the Subscriber), as defined by state law
    - Physically live or work in the 5-county area, our Service Area
- Your Domestic Partner as defined by and if specified as eligible by your Employer Group.
- Your Dependent child who is:
    - under **26 years** of age; your natural child, a legally adopted child, or a child for whom you are legal guardian or have legal custody as defined by state law
    - your stepchild (foster children are not eligible)
    - a child of non-custodial parent(s)
    - in your custodial care as appointed by court order
    - a child for which a court or qualified administrative order is imposed
    - you or your Spouse's Dependent child for whom you are required by court order to provide healthcare Coverage.

We will require proof, such as legal adoption or guardianship papers, income tax forms, court orders or administrative orders that a child qualifies as a Dependent for Coverage under this Agreement.

The enrollment of a Dependent child for Covered Benefits under this Contract shall terminate at the end of the month of the child's 26th birthday unless the Dependent child is totally and permanently disabled.



A Dependent who has had a prior Contract or Agreement with us terminated for Good Cause, as described in the **Glossary of Terms Section** or under any similar Sections of our other Agreements, is not eligible to enroll.

Court Ordered Coverage for Dependent Children in the Service Area

The Dependent who is eligible due to a court order will be allowed to apply. Other siblings of the court-ordered Dependent, who do not meet the eligibility requirements as explained above, will not be eligible for Coverage.

Dependents of Non-Custodial Parents

When a Dependent child has Coverage through a non-custodial parent, we shall:

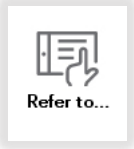
- Provide such information to the custodial parent as may be necessary for the child to obtain Covered Benefits.
- Permit the custodial parent or the Practitioner/Provider, with the custodial parent's approval, to submit claims for Covered Benefits without the approval of the non-custodial parent.
- Make payment on claims for Covered Benefits submitted by the custodial parent (as explained above) directly to the custodial parent, the Practitioner/Provider or the state Medicaid agency.

Residence of a Dependent Child

Dependent Student

Dependent Students attending school within the 5-county area may either receive care through their PCP or at the Student Health Center. A **Prior Authorization** form is not needed prior to receiving care from the Student Health Center.

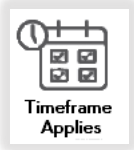
Dependent Students attending school outside of the 5-county area may also receive care at the Student Health Center without **Prior Authorization** from us. Services provided outside of the Student Health Center are limited to Medically Necessary services for the initial care or treatment of Emergency Healthcare Services or an Urgent Care situation.



For emergencies outside of the 5-county area, you may seek Emergency Healthcare Services from the nearest appropriate facility where emergency medical treatment can be provided. Refer to **Benefits Accidental Injury / Urgent Care / Emergency Healthcare Services / Observation / Trauma Services Section** for further information on Emergency Healthcare Services and follow-up care.

Total and Permanent Disability of an Enrolled Dependent Child

When an enrolled Dependent child reaches his or her **26th birthday** and is totally and permanently disabled, the Coverage of the Dependent under this Agreement will not terminate. The enrolled Dependent must be incapable of self-sustaining employment by reason of mental disability or physical handicap and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish us with proof of such disability, incapacity and dependence within **31 days** of the Dependent child's attainment of age 26. If we approve continued Coverage, we may request proof of the disability on each birthday after the two-year period following the attainment of age 26.



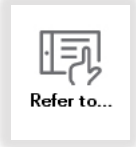
Medicare-Eligible Members (TEFRA)

Shortly before you turn age 65 or qualify for Medicare Benefits, you are responsible for contacting the local Social Security office to establish your Medicare eligibility. You should then contact your Group's benefits administrator to discuss your Coverage choices.

- If Medicare is Secondary (TEFRA)
    - If your Group is subject to the Tax Equity & Fiscal Responsibility Act (TEFRA) and if you are actively at work at age 65 and older, you may continue the Coverage provided under this Agreement until you retire. In that case, this Coverage will be primary over Medicare benefits. There may be other circumstances that allow you to retain this Coverage when you are eligible for Medicare. You should contact the Social Security Administration for more information.

- If Medicare is Primary
    - If you are eligible for Medicare and you select Medicare as your primary health plan, the Coverage under this Plan is not available to you.
- If your Group is not subject to the federal law (TEFRA) and is not required to offer Group Coverage that you may select to be primary over Medicare when you are actively working at age 65 and beyond the following may apply:
    - Active employees and their dependents who are enrolled in conventional coverage may also enroll in our Group healthcare Plans.
    - For Groups with 2-19 total employees, Medicare Parts A&B are considered the Primary insurance carrier and we would be the secondary carrier.
- If your Group does not offer Coverage secondary to Medicare, please refer to "Continuation of Coverage" later in this Section for more Coverage options.

Subscribers and Dependents Who May NOT Enroll



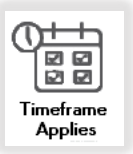
- A Subscriber's grandchild is not eligible for Coverage unless the grandchild meets the eligibility criteria for a Dependent.
- A child born of a Member, when the Member is acting as a surrogate parent, is not eligible for Coverage.
- A Subscriber and/or Dependent is not eligible to enroll for Coverage if either Subscriber or Dependent has had a prior Contract or Agreement with us terminated for Good Cause as described in the **Glossary of Terms Section** or under any similar Sections of our other Agreements, unless we review and approve the new enrollment, in writing.

Enrollment and Effective Dates

If you meet the Subscriber or Dependent eligibility criteria, you may enroll in our Coverage by submitting a completed Application, together with any required Prepayment, at the appropriate times as discussed below.

When Your Employer signs our Group Letter of Agreement (GLA) - The Initial Group Enrollment Period

A Subscriber and the eligible Dependents may enroll during the Initial Group Enrollment Period, after the Employer and our Company execute the Group Letter of Agreement (GLA). If you, as the Subscriber, were hired as a full-time employee and your employer is not waiving the initial waiting period, you must meet the Employer's waiting period requirements.



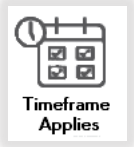
You (as the Subscriber) and your eligible Dependents must complete and sign an Application and submit it with any required Prepayment to the Group. We must receive the signed and completed Application, along with any required Prepayment, within **31 days** of the initial effective date of the Plan.

The Annual Group Enrollment Period

Each year there will be an Annual Group Enrollment Period. During the Annual Group Enrollment Period, Subscribers and their eligible Dependents who were previously eligible but have not previously enrolled in our Coverage may enroll. The effective date of Coverage for new Members who enroll during the Annual Group Enrollment Period shall be 12:01 a.m. on the date of the Contract Year for which they enroll. We must receive the signed and completed Application and any required Prepayment within **31 days** of the initial effective date of the Plan.

Newly Hired Employees During the Year

If you are hired by the Group after an Annual Group Enrollment Period, you must enroll, along with eligible Dependents, within **31 days** after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month following completion of the Group's eligibility requirements and submission of the completed and signed Application. If you do not enroll within the **31-day period**, the earliest time you and your eligible Dependents may enroll is the next occurring Annual Group Enrollment Period except as specifically described in the **Special Enrollment Section**.



Family Status or Employment Status Changes During the Year

During the Contract Year when you are currently enrolled as a Subscriber, you may make certain changes to your benefit election due to a change in family or employment status. We will require evidence of a change in family or employment status in order to change your benefit election. You must complete and sign an Application and submit it with any additional Prepayment amount, within **31 days** of the date of the change in family or employment status. Terminating Coverage for a Dependent from your benefit plan Coverage is not an event that allows you to change your benefit Plan.

We recognize the following family status changes as a reason for adding or removing Dependents:

- Marriage
    - Your newly acquired Spouse (and any children of the Spouse eligible for Coverage under this Section) is eligible to be enrolled as a Dependent. You must complete and sign an Application and submit it, along with any required Prepayment, to your Employer Group within **31 days** from the date of marriage. Coverage will become effective on the first day of the month following the date of marriage.

- Divorce or legal separation
    - You must notify us within **31 days** of the date of divorce or legal separation of the change in Dependent Coverage and submit any Prepayment amount. Coverage

will be effective as of the first day of the month following the date we receive the notification.

- Birth of a child
  - Your newborn or the newborn of your Spouse will be Covered from the moment of birth when enrolled as follows:
    - We must receive the signed and completed Application that was submitted to the Employer Group within **31 days** from the date of birth.
    - If enrollment of a newborn results in an increase to the amount of Prepayment due, the applicable Prepayment must be paid with the signed Application within the first **31 days** following the date of birth.

  - If the above two conditions are not met, we will not enroll the newborn for Coverage until the next following Annual Group Enrollment Period. Please refer to the **Benefits Section, Prior Authorization Section, Limitations Section and Exclusions Section** to fully understand the benefits and requirements for Maternity and newborn Coverage.
- Adoption of a child
  - A child under age 18 who is placed in your home for the purposes of adoption and for whom you have commenced adoption proceedings is eligible to be enrolled as a Dependent.
  - The child will be Covered from the date of placement for the purpose of adoption when we receive the signed and completed Application that was submitted to the Group and any applicable Prepayment made within **31 days** the date of placement.

  - The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.
  - Such child shall continue to be eligible for Coverage unless placement is disrupted prior to legal adoption. The legal obligation terminates when placement terminates or is disrupted.
- Legal Guardianship
  - If you or your Spouse becomes the legal guardian for any child pursuant to court order, the child is eligible to be enrolled as a Dependent. You must submit a completed, signed Application and any applicable Prepayment within **31 days** of the court and/or qualified administrative order granting guardianship.

  - The Dependent child will become a Member on the first day of the month following the date the order is filed with the clerk of the court. The Dependent child will continue to be eligible until such time as you or your Spouse are no longer the legal guardian for such child.

- Court ordered or qualified administrative ordered eligible Dependent Coverage
    - If you are required by a court or administrative order to provide Coverage for an eligible Dependent child, the Dependent child may be enrolled. You must submit a completed and signed Application and any applicable Prepayment within **31 days** of the court order. The Coverage for the eligible Dependent child will become effective on the date in accordance with the court or administrative order. If the court order does not stipulate an effective date, the Dependent child will become Covered effective the first day of the month following the date the order was filed as public record with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent child will be the first day of the month following the Employer's receipt of the request.
    - When a Subscriber, who is not enrolled in our Coverage, has been ordered by a court of law or by a qualified administrative order to provide healthcare Coverage for a Dependent child, the child is eligible to be enrolled as a Dependent provided the Subscriber has met the Group's waiting period requirements and the signed Application together with any required Prepayment is submitted within **31 days** from the date on which the Group receives the court and/or qualified administrative order. The Dependent child will become a Member on the day stipulated by the court order.
    - If the Subscriber, who is not enrolled in our Coverage, has not met the waiting period and other eligibility requirements, the Subscriber may not enroll and may not enroll the Dependent child until the date that eligibility requirements haves been met. The Subscriber must submit the Application and any Prepayment within **31 days** from the eligibility date. The Dependent will become a Member on the date of the Application.
    - Note: Only the eligible court-ordered Dependent(s) will be allowed to enroll as a result of the court and/or qualified administrative order. Other Dependents who are not enrolled may not enroll at this time.
- The last day of the month in which your Dependent child turns age 26 (when Dependent Coverage will terminate unless the Dependent child is as described in the **Totally and Permanently Disabled Dependent Child in this Section**)
- The death of your Spouse or Dependent child
- Disqualification or requalification of your Dependent

We recognize the following changes in Employment Status as a reason for making a change in your benefit election:

- A change in your (Subscriber) Spouse's employment such as loss of job or a new job that provides Dependent care assistance or other healthcare Coverage. Annual Group Enrollment for a Spouse's plan is not an employment status change.
- Unpaid leave of absence for the Subscriber or Dependent Spouse

- Significant change in the cost of a Spouse's current plan (**50%** or greater)
- Employment transfer that results in a change of residence

Any change in your Covered Benefit election that you apply for because of a family status or employment status change will become effective on the first day of the month following the date of the status change if you have met the waiting period and other employer Group eligibility requirements. The only exceptions would be the birth and adoption of a child, or court-ordered Coverage, where the change in Coverage would be effective as of the date of birth or placement for adoption and a court-ordered change if the court specifies an effective date.

Special Enrollment for Active Employees and Their Dependents

If you, as a Subscriber, failed to enroll in our Coverage during a previous Annual Group Enrollment Period or within **31 days** after meeting your Employer's waiting period and you became originally eligible, you may enroll during the year due to a Special Enrollment qualifying event.

There are three Special Enrollment qualifying events that will allow you to enroll other than at the Annual Enrollment Period. They are as follows:

- Change in family status by acquiring a new Dependent(s)
- Loss of other prior Coverage
- Loss of Medicaid/CHIP eligibility

You must apply within **31 days** from the date of a Special Enrollment qualifying event, or within **60 days** from the loss of Medicaid/CHIP eligibility. If you do not request Special Enrollment within the required period specified, you will not be eligible to enroll until the next Annual Enrollment Period.

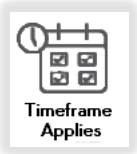
Special Enrollment - Change in Family Status

If you (Subscriber) are eligible and not enrolled and if you acquire a new Dependent due to marriage, the birth of your natural child or adoption of a child, you and your eligible Dependents may apply for Coverage under the Special Enrollment qualifying event. You must complete, sign and submit an Application, along with required Prepayment, within **31 days** of the marriage, birth or placement for adoption. If you fail to submit an Application within **31 days** of the change in family status, special enrollment is not available.

In the case of marriage, you and your Spouse and any Dependent children acquired because of the marriage may enroll.

In the case of a newborn or adopted child, you, your Spouse, and the newborn or adopted child who triggered the event may enroll. The other siblings who are not enrolled may not enroll until the next Annual Group Enrollment Period.

Effective date of the Family Special Enrollment:



- In the case of marriage, the first day of the first calendar month following the date of the marriage, provided that we receive the completed Application and any required Prepayment within **31 days** of the date of marriage.
- In the case of a Dependent's birth, the date of such birth provided that we receive the completed Application and any required Prepayment within **31 days** of the date of birth.
- In the case of adoption or placement for adoption, the date of such adoption or placement for adoption provided that we receive the completed Application and any required Prepayment within **31 days** of the date of adoption.

Special Enrollment - Loss of Coverage

If you (an eligible Subscriber) and/or your eligible Dependent initially declined to enroll in our Coverage because you or your Dependent had other medical coverage and later involuntarily lost the other coverage, the eligible person may enroll as a Subscriber or as a Dependent after the initial eligibility period if the person loses coverage under all of the following circumstances:

- The person was covered under a Group Health Benefits Plan or had individual health insurance coverage at the time the person was initially eligible to enroll.
- At the time, the employee (Subscriber) of the Group was first eligible to enroll, the employee stated, that the employee and/or eligible Dependents were not enrolling because of such other coverage. The employer may require this in writing.
- The person's coverage under the other plan or insurance:
    - Was under a Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 continuation provision and the coverage under that provision was exhausted (and not voluntarily terminated).
    - Was not under a COBRA continuation period and either the coverage was terminated as a result of loss of eligibility or employer contributions toward the coverage were terminated.

You must submit a signed Application with any required Prepayment within **31 days** of the date coverage was terminated either under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or the date the other coverage (or the other employer's contribution toward Coverage) was terminated.

If the Subscriber and/or Dependent does not enroll during the **31-day** Special Enrollment period, enrollment in our Coverage can occur only during a subsequent Annual Group Enrollment Period.

There are no Special Enrollment periods for you or your Dependents who apply for Continuation, Conversion Coverage or Extension of Benefits. You must apply for and enroll in the Coverage within the time limit required for each Coverage. Refer to **each of these Sections** for information on each Coverage.

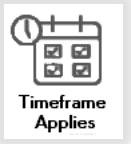
Other Special Enrollment Periods

- **Dependent eligibility for special enrollment periods:** A qualified individual's dependent, may become eligible for a QHP because of a relationship to a qualified individual enrollee. Dependent eligibility for a special enrollment period is not limited to household members on whose behalf APTCs are provided or who are enrolled in the same QHP.
- **Special enrollment period for new citizenship/immigration status:** A special enrollment period related to citizenship or immigration status will apply to both the newly qualified individual and his or her dependents, but that such special enrollment period only applies to a person who was not previously a citizen or lawfully present, not to someone who is switching between these statuses.
- **Special enrollment period for foster placement:** Placement of a foster child is a triggering event for a special enrollment period.
- **Special enrollment period for enrollees who become APTC eligible or experience CSR changes during the coverage year:** QHP enrollees who are determined newly eligible for APTCs, CSRs, or different CSRs during the benefit year. This special enrollment period is extended to qualified individuals' dependents enrolled in the same QHP and similarly determined newly eligible for APTCs, CSRs or different CSR levels.
    - Qualified individuals and their dependents enrolled in an employer sponsored plan that meets minimum value and affordability standards who thereafter become APTC/CSR eligible because they are determined to be ineligible for qualifying coverage are also eligible for a special enrollment period. This includes circumstances where an employer is discontinuing or changing coverage within the next **60 days**. The Exchange must permit the individual losing employer coverage within **60 days** to access the special enrollment period and select a plan prior to the end of existing coverage. These individuals would not be eligible for advance payment of the premium tax credit until their employer & sponsored coverage ends.
- **Special enrollment period coverage effective dates:** Presbyterian is required to ensure coverage effective dates for special enrollments due to birth, adoption and foster care placement on the date of the triggering event. In cases of special enrollments due to marriage or loss of minimum essential coverage, the Plan must ensure coverage effectuation on the first day of the following month. Plans are otherwise required to ensure that coverage obtained during a special enrollment period is effective on an appropriate date based on the circumstances of the special enrollment period.
- **Special enrollment period for "exceptional circumstances:"** Presbyterian may allow special enrollment periods for exceptional circumstances.

CHIPRA Special Enrollment Period and Qualifying Event (Children's Health Insurance Program Reauthorization Act)

In accordance with the Children's Health Insurance Program (CHIP) provisions as currently defined under federal law, you and/or your eligible Dependents who are not currently enrolled in our Coverage, may enroll in our Plan. There are two circumstances when this CHIPRA Special Enrollment Period may apply.

- Loss of Medicaid/CHIP Eligibility
    - If you, as an eligible Subscriber, chose not to enroll in our Coverage for yourself and/or Dependent(s) during a previous enrollment period because you and/or your Dependent(s) were covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan, the person who loses Medicaid/CHIP eligibility may enroll in our Coverage. If you, as an eligible Subscriber, are not enrolled for Coverage, you must enroll in our Coverage at the same time as your Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.



    - You must submit a completed, signed Application within **60 days** of the loss of Medicaid or CHIP coverage. We will require documentation from the State supporting the fact that the person who had the Medicaid/CHIP Coverage lost the Coverage voluntarily. Coverage will start no later than the first day of the month after we receive your Application and any required Prepayment.
    - If you, as Subscriber, lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and your Dependents, including your Spouse. If your Dependent lost Medicaid/CHIP coverage, CHIPRA Special Enrollment is available to you and that Dependent (not to other Dependents).

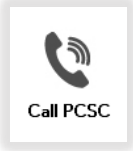
Full, Accurate and Complete Information

You, as a Subscriber, must fully and accurately complete and sign an Application for Coverage as required. False or fraudulent statements or intentional misrepresentations of material fact provided in an Application may result in the Termination of all Coverage for you and your Dependents.

A retroactive Termination of Coverage or rescissions (back to the initial date of enrollment) for fraud or intentional misrepresentation of material fact, except for those attributable to failure to pay prepayments, premiums or contributions may occur. This rule does not apply to prospective Termination of Coverage.

We will provide at least **30 days** advance written notice to each participant who would be affected prior to rescinding coverage.

Change in Address, Family Status and Employment



Changes in your Dependents, marital status, employment or address may affect your Coverage under this Agreement. Please notify your Employer Group's human resources office and ask that they notify us of all changes. You may notify us directly by calling our Presbyterian Customer Service Center at **(505) 923-7521 or 1-855-923-7521**, Monday through Friday, from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**. Or visit our website at **www.phs.org**.

Termination of Coverage

The Employer Group Letter of Agreement (GLA) shall be cancelled and shall terminate in the event any one of the following conditions occurs:

- **Termination of the Employer Group for Non-payment**
  - In the event any Contract charge, including a Prepayment and any applicable finance charge or charges, is not paid to us when it is due from the Group, we shall notify and mail a Notice of Cancellation to the Group within **30 days**. The Group shall then immediately forward to each Subscriber, by first-class mail at his or her current address, a legible copy of such notice. Termination of this Agreement shall not become effective sooner than **30 days** after the date the notice is hand delivered or mailed to each Subscriber.
  - If we receive payment of the Contract charge (including any Prepayment and all other applicable amounts and charges) within **15 days** of the issuance of the Notice of Cancellation, it shall be sufficient to prevent cancellation and termination under this paragraph. If we do not receive payment of such charge within this **15-day period**, we may, at our option, either:

    - Require that a new Application for Coverage be submitted, notifying the Group of the conditions under which a new Contract will be issued or the original Application reinstated; or
    - Elect to abide by this cancellation by returning to the Group, within **20 business days** after receipt, any Prepayment for Coverage for periods after the effective date of cancellation.
  - Cancellation and termination of this Agreement under this paragraph shall become effective as of the last date of Prepayment. We shall be entitled to recover from the Group or from the Subscriber any and all payments for Covered Benefits made on behalf of any Subscriber or the Subscriber's Dependent(s) after the last date of the period for which Prepayment was received.
- **Voluntary Termination by the Employer Group of the Group Letter of Agreement (GLA)**
  - Voluntary Termination of Coverage by the Group is governed by the terms of the GLA. Such termination shall only be effective as of the last day of the month.
- **Our Termination of your Employer Group**

- Our termination of the Group is governed by the terms of the GLA and is in accordance with federal and state laws. Our termination or cancellation of the Group shall automatically terminate this Agreement. Upon our cancellation or termination of our Contract with the Group, the Group shall promptly mail a legible copy of the Notice of Cancellation to each Subscriber at the Subscriber's current address and shall promptly provide us with proof of such mailing and the date thereof.
- Such cancellation shall become effective no sooner than **30 days** after the date the Group mails the notice to Subscribers. The notice requirement in this paragraph does not apply to our refusal to renew any GLA that does not contain an automatic renewal provision.

- **Termination of your Group Subscriber Agreement**
  - This Agreement shall be cancelled and your (Subscriber and Dependent) Coverage shall terminate in the event any one of the following conditions occurs:
    - We will not terminate your Coverage for nonpayment of Cost Sharing amounts during any period in which you are Hospitalized and receiving treatment for a life-threatening condition. In addition, we will not terminate your Coverage for refusal to follow any prescribed course of treatment.
    - False Material Information/Rescissions
      - On the date we specify, this Agreement will terminate if you (the Subscriber) have knowingly given false material information in connection with your eligibility or enrollment of yourself or any of your Dependents, provided we send written notice to you (the Subscriber) at least **30 days** in advance of such termination. In such case we, at our sole discretion, may terminate Coverage for you and all of your Dependents, and may make such termination effective retroactively as of the date of enrollment. You shall be responsible for payment for all Healthcare Services rendered hereunder as of the effective date of such termination and shall reimburse us for all such Healthcare Benefit payments that we made on your behalf or on behalf of any of your Dependents.

    - Military Service
      - Coverage for you (Subscriber) and your eligible Dependents will terminate at the end of the month during which you entered into active military duty (except for temporary duty of **30 days** or less).
    - At the end of the Contract month in which you (the Subscriber) cease to physically live within the 5-county area or work for an employer headquartered in the 5-county area, our Service Area. Coverage for all Dependents will terminate on the same date as your (the Subscriber's) coverage
    - At the end of the Contract month in which you cease to be eligible as a Subscriber or Dependent.

- On the date that adoption placement for the child originally placed for adoption, is disrupted prior to legal adoption, and is removed from placement.
- As of the date on which you permit the use of our Identification Card by any other person, we may, at our discretion, terminate Coverage for you and for all Members of your family. We must send written notice to you (Subscriber) at least **30 days** in advance of such termination.

In the event that premiums owed to us has remained unpaid through the grace period allowed for the payment, Presbyterian will be liable for valid claims for Covered losses prior to the grace period except that Presbyterian will be entitled to the premium due for coverage provided during the grace period. As required by state regulation enforced by New Mexico Division of Insurance, Members Covered under our contract with any employer group must be notified a minimum of **30 days** prior to loss of coverage. If payment in full is not received by the deadline, Presbyterian will notify your Covered employees, adhering to the **30-day** notification requirement, and you will be responsible for an additional month of premium. Presbyterian will not recognize claims incurred after the end of the grace period if premiums remain unpaid.

If you or any of your Dependents are terminated for Good Cause, as defined in the **Glossary of Terms Section**, then you or any of your Dependents are not eligible for COBRA continuation or Individual Conversion.

We will not terminate Coverage under this Agreement for any Member based solely upon the Member's health status, requirements for Healthcare Service, race, gender, age, sexual orientation, or for refusal to follow a prescribed course of treatment. If you or your Covered Dependents believe that Coverage was terminated due to health status or healthcare requirements, you may Appeal the cancellation to the Superintendent of Insurance, at:

Mailing Address: Office of Superintendent of Insurance
Attention: External Review Request
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
Email: **mhcb.grievance@state.nm.us**
Fax: (505) 827-4734

Unless we agree, in writing, no Covered Benefits shall be provided under this Agreement following the date this Agreement terminates including, but not limited to, when you or your Covered Dependent remains in the Hospital after the date of termination of this Agreement.

We shall be entitled to recover from you (Subscriber) any and all payments for Covered Benefits made on behalf of you or your Dependents after the last date this Agreement was in force.

Notice of Termination to Members

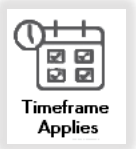
If this Agreement is terminated for cause, we will send a Notice of Cancellation to you (the Subscriber) no less than **30 days** prior to the effective date of termination.

- The notice will be dated
- State the reason(s) for termination
- State your right to file a Complaint with the Superintendent of Insurance if you feel you have been wrongly dis-enrolled (had your Coverage terminated)
- Provide information about your ability to enroll in a conversion plan
- Include other matters required by law, including information related to premium refunds, if any, and reinstatement

Continuation of Coverage of Your Group Plan

If your Coverage would otherwise terminate because of a loss of eligibility as a Subscriber or Dependent, you may be entitled to continue your Coverage under one of the following options:

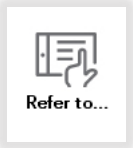
- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985**
  - Most Employer Groups with 20 or more employees are required to offer continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.
  - If you lose eligibility for Coverage and if you are entitled to COBRA Coverage, you may continue your Coverage as a Member of the Employer Group under this Agreement and in accordance with the GLA for the period of time allowed under COBRA unless and until:
    - You terminate your Coverage.
    - Your Coverage under this Agreement is terminated for Good Cause.
    - You fail to make a timely election for COBRA Coverage.
    - You fail to make timely payments for your COBRA Coverage.
    - You become Covered under another Group Healthcare Plan.
    - You become entitled to Medicare benefits.
  - Your Group's benefit administrator will provide you with information about your eligibility for COBRA. If you are eligible, you (the Subscriber) or your eligible Dependent must elect COBRA Coverage within **60 days** of the date you lose eligibility for Coverage under this Agreement. Your COBRA Coverage will be effective only if we receive your COBRA Application within **60 days** after the date your Group Coverage under this Agreement terminates.



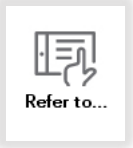
  - If you or your eligible Dependent elects COBRA Coverage and submits your Application, you will have **45 days** from the date of the election to pay the initial Prepayment due. All subsequent Prepayments will be paid on a monthly basis. There is a **30-day** grace period to pay Prepayments. If the Prepayment is not paid before the expiration of the grace period, COBRA continuation benefits will end.

- Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation.

- **State Continuation of Group Coverage**
  - Employer groups with fewer than 20 active employees (or otherwise not required to offer COBRA continuation) may provide continuation of non-COBRA Coverage.
  - You, on behalf of yourself and your Dependent(s), upon termination of employment with the Employer Group, have the right to continue your Group Coverage for six months under state law. At the end of the six months, you may convert your Coverage to the individual conversion option that we offer, in accordance with the **non-Group Coverage Section**.



  - An enrolled Dependent, upon loss of eligibility for Coverage under this Agreement (following the continuation of Group Coverage for six months under state law), may have the option of converting the Group Coverage to the individual conversion option we offer. The circumstances and conditions under which conversion is allowed are specified in the **non-Group Coverage Section**.
  - Coverage under this State Continuation option will terminate prior to the end of the six-month period of Coverage in the event:
    - You terminate your Coverage.
    - Your Coverage under this Agreement is terminated for Good Cause.
    - You fail to make a timely election for continuation Coverage.
    - You fail to make timely payments for your continuation Coverage.
    - You become Covered under another Group health plan.
    - You become entitled to Medicare benefits.
  - State continuation Coverage is effective only if we receive your continuation Application and the applicable Prepayment within **31 days** after the date your Group Coverage under this Agreement terminates.
  - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for state continuation Coverage.



- **Eligibility for Individual Conversion Option**
  - If you are still Covered by Presbyterian Health Plan, Inc., at the expiration of any continuation period (whether under COBRA or state law), you will have the option of converting your continuation Coverage to the Individual Conversion Option we provide in accordance with the provisions of the **non-Group Coverage Section**.
  - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for COBRA continuation, state continuation or non-Group/Individual Conversion Option.
- **Conversion to non-Group Coverage (Individual Conversion Option)**
  - You may be eligible to enroll in non-Group coverage as follows:
    - You (on behalf of yourself and your enrolled Dependents) shall have the right to convert to a non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon exhausting the benefits of your COBRA or state continuation coverage.

        - An enrolled Dependent Member under this Agreement shall have the right to convert to a separate, non-Group contract (called Individual Conversion Coverage or non-Group Coverage) upon termination of the Dependent's benefit period under COBRA or state continuation, if any.
    - When your (Subscriber) Dependent Spouse elects Conversion coverage, the Dependent Spouse may include coverage for Dependent children for whom the Dependent Spouse has responsibility for care and support.
    - At the time of Conversion, the Individual Conversion or non-Group coverage provided shall be your choice of one of our available policies. However, at the time of Conversion, if you or your eligible Dependent are eligible for Medicare, the right to convert may be limited to coverage under a Medicare Supplemental Insurance Contract, which are available from other carriers.
    - Individual Conversion Coverage is effective only if we receive your Individual Conversion Application and the applicable Prepayment within **60 days** after the date your Group Coverage under this Agreement terminates.
    - Members terminated for Good Cause, as defined in the **Glossary of Terms**, are not eligible for the Individual Conversion Option.
    - You, as the Subscriber, may terminate Individual non-Group Membership Coverage with no less than **30 days** written notice.
- **Extension of Benefits for the Totally Disabled**
    - In the event you are totally disabled on the date your Group Coverage terminates, healthcare Coverage may be continued for up to 12 consecutive months. To claim an extension of benefits, you must notify us within **31-days** of the Group Coverage termination date and provide evidence of your total disability.

    - For purposes of this section, totally disabled means that an individual is prevented, solely because injury or disease, from performing their regular or customary occupational duties or is incapable of doing most of the normal activities and tasks for that person's age and family status. In order to qualify for benefits under this extension, you must have been totally disabled on the date that the Group Coverage terminates, incur an expense directly resulting from that particular disability and such expense would have been a Covered Benefit before termination.

Our Responsibility When Your Group Contract Is Replaced

In the event that your contract with another carrier is replaced by Presbyterian due to the prior carrier's discontinuance of the contract, you will be eligible and covered for benefits under this agreement according to the eligibility requirements of this agreement and your employer. Persons not eligible for coverage under this agreement will be covered by Presbyterian if the individual was covered under the previous carrier's plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under this agreement. Coverage provided will be according to the level of benefits described under this agreement reduced by benefits provided or payable by the prior plan. Benefits will be provided by Presbyterian until the earliest of the following dates: the date the individual becomes eligible

under this agreement and their employer or the date the individual's benefits would terminate in accordance with termination provisions under this agreement. Conversion privileges will be granted to those individuals whose benefits cease. Presbyterian shall give credit for the satisfaction or partial satisfaction for any Deductibles, Coinsurance, Copayments, or waiting periods that were satisfied under the prior plan providing similar benefits. The credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the Deductible provision of the prior carrier's plan during the **90 days** preceding the effective date of this plan, but only to the extent these expenses are recognized under the terms of this agreement and are subject to a similar Deductible provision. In any situation where a determination of the prior carrier's benefit is required by Presbyterian, Presbyterian will request the prior carrier to furnish a statement sufficient to permit verification of the benefit determination. The benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of Presbyterian. This determination will be made as if coverage had not been replaced by Presbyterian.

Discontinuance of Your Plan

In the event that PHP decides to discontinue offering this plan, PHP will provide a notice to you at least **90 days** prior to the date of discontinuing the coverage. You will be offered other available coverage PHP offers in the individual market. In the event that PHP decides to discontinue all coverage in the individual market, PHP will notify you of this at least 180 days prior to the date of discontinuance.

Guaranteed Renewability

An issuer may non-renew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

- **Non-payment of Premiums -** The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

- **Fraud** - The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

- **Violation of Participation or Contribution rules** – In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph the following apply:

    - (i) The term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

- (ii) The term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

❖ **Termination of product** - The issuer is ceasing to offer coverage in the market in accordance with paragraph *Discontinuing a particular type of coverage or Discontinuing all coverage* section and applicable State law.

❖ **Enrollees' movement outside of the service area** - For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; provided the issuer provides notice in accordance with the requirements of *Discontinuing a particular type of coverage* section.

❖ **Association membership ceases -** For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

❖ **Discontinuing a particular type of coverage** - An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:

- (1) Provides notice in writing, in a form and manner specified by the Secretary, to each individual provided coverage of that type of health insurance at least 90 calendar days before the date the coverage will be discontinued.
- (2) Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.
- (3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

❖ **Discontinuing All Coverage** - An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.

- (1) Provides notice in writing to the applicable State authority and to each individual of the discontinuation at least 180 days before the date the coverage will expire.
- (2) Discontinues and does not renew all health insurance policies it issues or delivers for issuance in the State in the individual market.

- (3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.
- (4) For purposes of this section, subject to applicable State law, an issuer will not be considered to have discontinued offering all health insurance coverage in a market in a State if -
  - (i) The issuer (in this paragraph referred to as the initial issuer) or, if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, offers and makes available in the applicable market in the State at least one product that is considered in accordance with 45 CFR § 144.103 of this subchapter to be the same product as a product the initial issuer had been offering in such market in such State; or
  - (ii) The issuer -
    - **(A)** Offers and makes available at least one product in the applicable market in the State, even if such product is not considered in accordance with 45 CFR § 144.103 of this subchapter to be the same product as a product the issuer had been offering in the applicable market in the State;
    - **(B)** Subjects such new product or products to the applicable process and requirements established under 45 CFR Part 154 of this title as if such process and requirements applied with respect to that product or products, to the extent such process and requirements are otherwise applicable to coverage of the same type and in the same market; and
    - **(C)** Reasonably identifies the discontinued product or products that correspond to the new product or products for purposes of the process and requirements applied pursuant to paragraph of this section.
- (5) For purposes of this section, the term, *controlled group,* means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a narrower group as may be provided by applicable State law.

❖ **Prohibition on market reentry -** An issuer who elects to discontinue offering all health insurance coverage under *Discontinuing all coverage* section may not issue coverage in the market and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

❖ **Exception for uniform modification of coverage –**

- (1) An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a product offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.

- (2) For purposes of *Discontinuing all coverage* of this section, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

  - (i) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

  - (ii) The modification is directly related to the imposition or modification of the Federal or State requirement.

- (3) For purposes of this section, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:

  - (i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or if the issuer that is a member of a controlled group (as described in *Discontinuing all coverage* section), any other health insurance issuer that is a member of such controlled group;

  - (ii) The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

  - (iii) The product continues to cover at least a majority of the same service area;

  - (iv) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

  - (v) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of ±2 percentage points (not including changes pursuant to applicable Federal or State requirements).

- (4) A State may only broaden the standards in paragraphs (iii) and (iv) of this section.

❖ **Application to coverage offered only through associations -** In the case of health insurance coverage that is made available by a health insurance issuer in the individual market only

through one or more associations, any reference in this section to an "individual" is deemed to include a reference to the association of which the individual is a member.

- **Notice of renewal of coverage -** If an issuer is renewing grandfathered coverage as described in *General rules* of this section, or uniformly modifying grandfathered coverage as described in *Exception for uniform modification of coverage* of this section, the issuer must provide to each individual written notice of the renewal at least 60 calendar days before the date the coverage will be renewed in a form and manner specified by the Secretary.

General Provisions

This Section explains important information and provisions not covered in other sections of this Agreement.

Amendments (Group)

This Group Subscriber Agreement (Agreement) and the Group Letter of Agreement (GLA) shall be subject to amendment, modification, or termination in accordance with their provisions or by mutual agreement in writing between us and the Group. By electing Coverage or accepting benefits under this Agreement, you and all Members legally capable of contracting, agree to all the terms, conditions, and provisions of this Agreement and the GLA.

Assignment

All your rights to receive benefits and services are personal and may not be assigned.

Entire Contract

This Agreement, the Summary of Benefits and Coverage, any amendments, Endorsements, supplements or riders, the GLA or the non-Group Membership Letter of Agreement, the Employee Action Form and/or Universal/Uniform Medical Assessment Form (Application) completed upon enrollment (if applicable) by the Subscriber Covered hereunder and our issued Identification Card constitute the entire Contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties.

Execution of Contract - Application for Coverage

The parties acknowledge and agree that your signature or execution of the Application shall be deemed to be your acceptance of the Contract, including the GLA and this Agreement. All statements, in the absence of fraud, made by any applicant (you and/or your Dependents) shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Employee Action Form and/or Uniform Medical Assessment Form, which is an Application for Coverage.

Federal and State Healthcare Reform

We shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects our obligations under this Agreement, this Agreement will be deemed automatically amended such that we shall remain in compliance with the obligations imposed by such law, rule or regulation.

Fraud

We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Practitioner/Provider activity and Member activity.

Practitioner/Provider Activity

If you suspect that a Practitioner, pharmacy, Hospital, facility or other Healthcare Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation. There may be an error.

- Charged for services that you did not receive
- Billed more than one time for the same service
- Billed for one type of service, but gave you another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information (such as changing your diagnosis or changing the dates that you were seen in the office)

If you are unable to resolve the issue, or if you suspect any other suspicious activity, please contact our Special Investigative Unit (SIU) hotline at **(505) 923-5959** or toll-free within New Mexico at **1-800-239-3147**. This confidential voicemail box is available **24 hours** a day. Any information you provide will be treated with strict confidentiality. When reporting suspected health insurance fraud, you may remain anonymous. You can also contact the SIU via email at:

Address: Presbyterian Health Plan
Special Investigative Unit (SIU)
P.O. Box 27489
Albuquerque, NM 87125-7489

Email: **PHPFraud@phs.org**

Online: **https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx**

Member Activity

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information
- Allowing someone else to use your ID Card
- Forging or selling prescriptions

- Misrepresenting a medical condition in order to receive Covered Benefits to which you would not normally be entitled

Governing Law

This Agreement is made and shall be interpreted under the laws of the State of New Mexico and applicable federal rules and regulations.

Identification Cards

We issue Identification (ID) Cards to you, pursuant to the GLA, for identification purposes only. Possession of our ID Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. If you or any family Member permits the use of your ID Card by any other person, all your rights and other Members of your family pursuant to this Agreement may be immediately terminated at our discretion. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Contract shall be charged therefore at the rates generally charged in the area for medical, Hospital and other Healthcare Services.

Legal Actions

No action at law or in equity shall be brought to recover on this Agreement by the Group or a Member prior to the expiration of **60 days** after written proof of loss has been furnished, in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of **3 years** after the time written proof of loss is required to be furnished.

Misrepresentation of Information

If, in the first **2 years** from the effective date of your and/or your Dependents Coverage, we determine that you intentionally omitted information from your Employee Action Form, the Universal/Uniform Medical Assessment form or other Coverage Application and/or you provided fraudulent or false information, the Coverage for you and/or your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply and you will be required to pay for all benefits that we have provided.

Misstatements

No misstatements, except fraudulent misstatements, made by the applicant in the Employee Action Form, the Universal/Uniform Medical Assessment Form or other Application for Coverage for this Contract shall be used to void the Contract or to deny a claim for loss incurred or disability (as defined in this Group Subscriber Agreement).

Notice

If we are required or permitted by this Agreement to give any Notice to the Group, Subscriber or Member, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to the Group, Subscriber or Member at the address of record on file at our principal office. The Group is solely responsible for ensuring the accuracy of its addresses and the Subscriber and/or Member is solely responsible for ensuring the accuracy of his/her address of record on file with us.

Policies and Procedures

We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

Reinstatements

We may reinstate this Agreement after termination without the execution of a new Application or the issuance of a new Identification Card or any notice to the Subscriber or Member, other than the unqualified acceptance of an additional payment from the Group or Remitting Agent.

Right to Examine

We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Waiver by Agents

No agent or other person, except an officer of Presbyterian Health Plan has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making payment, or to bind Presbyterian Health Plan by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Agreement or the applicable GLA or non-Group Membership Letter of Agreement signed by one of the aforesaid officers.

Workers' Compensation Insurance

This Agreement is not in lieu of and does not affect any requirement for Coverage by the New Mexico Workers Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the New Mexico Workers Compensation Act. More specifically, an employee may waive workers' compensation Coverage provided that the following criteria have been met:

- The "employee" is an executive officer of a professional or business corporation; and

- The "employee" owns ten percent (**10%**) or more of the outstanding stock of the professional or business corporation.

For purposes of the New Mexico Workers Compensation Act, an "executive officer" means the chairman of the board, president, vice-president, secretary or treasurer of a professional or business corporation.

In the event that an employee chooses to opt out of workers' compensation Coverage, and meets the criteria as stated above, PHP will provide 24-hour healthcare Coverage to those employees, subject to the eligibility requirements for Coverage with PHP. In addition to meeting all of PHP's eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with PHP to become effective.

Glossary of Terms

This Section defines some of the important terms used in this Agreement. Terms defined in this Section will be capitalized throughout the Agreement.

Abortion (excepted and non-excepted) Excepted are services defined as such by the Affordable Care Act (ACA). Excepted means the pregnancy is the result of rape or incest, or the life of the pregnant woman would be endangered unless an abortion is performed. Non-excepted means abortion services that do not meet this criteria.

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.

Administrative Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding any aspect of a Health Benefits Plan other than a request for Healthcare Services, including but not limited to:

- Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of Healthcare Services
- Claims payment, handling or reimbursement for Healthcare Services
- Terminations of Coverage

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Adverse Determination Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding an Adverse Determination.

Agreement means this Group Subscriber Agreement, including supplements, Endorsements or riders, if any.

Alcoholism means alcohol dependence or alcohol use disorder meeting the criteria as stated in the (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Ambulance Service means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

Annual Group Enrollment Period means a period of at least **10 working days** prior to the expiration of each Contract Year mutually agreed to by our company and the Group, during which eligible Subscribers are given the opportunity to enroll themselves and their eligible Dependents under the Agreement without providing satisfactory evidence of good health.

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Contract Year that is the most the Member will pay (Cost Sharing responsibility) for that Contract Year.

Appeal means a request from a Member, or their representative, or a Practitioner/Provider who is representing a Member, to Presbyterian Health Plan, for a reconsideration of an Adverse Determination (denial, reduction, suspension or termination of a benefit).

Application means the forms, including the Employee Action Form and required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for our Coverage.

Authorized means **Prior Authorization** was obtained (when required) prior to obtaining Healthcare Services both In-network and Out-of-network (outside of the 5-county area).

Authorization means a decision by a Healthcare Insurer that a Healthcare Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Healthcare Insurer's requirements for Coverage and Medical Necessity, and the requested Healthcare Service is therefore approved. See **Certification**.

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 specified; Rett's Disorder; and Childhood Disintegrative Disorder.

Balance Billing is when a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is

$70, the provider may bill you the remaining $30. A preferred provider may not balance bill you for Covered services.

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

Biosimilar Drug is a biological product that is highly similar to an existing FDA approved product. It has no meaningful difference in terms of safety, purity, and potency.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection or treatment of cancer that is being provided in the 5-county area.

Cardiac Rehabilitation means a program of therapy designed to improve the function of the heart.

Certification of Service means a determination by a Health Insurance carrier that a Healthcare Service requested by a Healthcare Professional or Covered Person has been reviewed and, based upon the information available, is a Covered Benefit and meets the carrier's requirements for Medical Necessity, appropriateness, healthcare setting, level of care, and effectiveness, and the requested Healthcare Service is therefore approved. The Certification of Service can take place following the health carrier's utilization review process.

Certified Nurse Midwife means any Person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

Certified Nurse Practitioner means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the board of nursing.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent Person (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Coinsurance is a Cost Sharing method that requires a Covered Person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; Coinsurance rates may differ for different types of services under the same Health Benefits Plan.

Complaint means the first time we are made aware of an issue of dissatisfaction that is not complex in nature. For more complex issues of dissatisfaction see definition for **Grievance**.

Continuous Quality Improvement means an ongoing and systematic effort to measure, evaluate and improve a Health Insurance carrier's processes and procedures in order to continually improve the quality of Healthcare Services provided to Covered Persons.

Contract means the Application submitted as the basis for issuance of this Group Subscriber Agreement (Agreement). This Agreement including the *Summary of Benefits and Coverage*, any supplements, Endorsements or riders, the Application, medical questionnaire (if applicable), the issued Identification Card, and the applicable Group Letter of Agreement or non-Group Membership Letter of Agreement constitute the entire Contract.

Contract Year means the period, or other length of time covered by the Contract, that we and the Group mutually agree to, as specified in the Group Letter of Agreement (GLA).

Conversion Subscriber means a Member who has converted to our non-Group (Individual Conversion) Membership as a Subscriber, pursuant to the Continuation of Coverage Section.

Copayment is a Cost Sharing method that requires a Covered Person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the Health Insurance carrier paying the allowed balance; there may be different Copayment amounts for different types of services under the same Health Benefits Plan.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means a Copayment, Coinsurance, Deductible, or any other form of financial obligation of a Covered Person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the Health Benefits Plan.

Coverage/Covered means benefits extended under this Agreement, subject to the terms, conditions, **limitations, and exclusions** of this Agreement.

Covered Benefits means those Healthcare Services to which a Covered Person is entitled under the terms of a Health Benefits Plan.

Covered Person or Enrollee means a Subscriber, policyholder or Subscriber's enrolled Dependent or Dependents, or other individual participating in a Health Benefits Plan.

Craniomandibular means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

Culturally and Linguistically appropriate manner of notice means the notice that meets the following requirements:

- The Healthcare Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language.
- The Healthcare Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Healthcare Insurer.

For purposes of this definition, with respect to an address in the 5-county area to which a notice is sent, a non-English language is an applicable non-English language if ten percent (**10%**) or more of the population residing in the county is literate only in the same non-English language, as determined by the Department of Health and Human services (HHS). The counties that meet this ten percent (**10%**) standard, as determined by HHS, are found at **http://cciio.cms.gov/resources/factsheets/clas-data.html** and any necessary changes to this list are posted by HHS annually.

Custodial or Domiciliary Care means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's normal 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.

Custom-fitted 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.

Cytologic Screening (PAP Smear) means a Papanicolaou test or liquid based cervical cytopathology, a Human Papillomavirus Screening test and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible means a fixed dollar amount that a Covered Person may be required to pay during a benefit period before the Health Insurance carrier begins payment for Covered Benefits; Health Benefits Plans may have both individual and family deductibles and separate deductibles for specific services.

Dependent means any Member of a Subscriber's family who meets the requirements of the Eligibility, Enrollment and Effective Dates Section of this Agreement, who is enrolled as our Member, and for whom we have actually received an Application.

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Doctor of Oriental Medicine means a person licensed as a physician to practice acupuncture and oriental medicine with the ability to practice medicine and collaborate with other healthcare providers. A doctor of Oriental Medicine may serve as a Primary Care Practitioner provided that they are 1) acting within his or her scope of practice as defined under the relevant state licensing law; 2) meets the PHP eligibility criteria for healthcare practitioners who provide primary care; and 3) agrees to participate and to comply with PHP's care coordination and referral policies.

Durable Medical Equipment means equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

Emergency Care means healthcare procedures, treatments, or services delivered to a Covered Person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a Reasonable Layperson, to result in:

- Jeopardy to the person's physical or mental health; or
- To the health or safety of a fetus or pregnant person
- Serious impairment of bodily functions
- Serious dysfunction of any bodily Organ or part
- Disfigurement to the person

Emergency Medical Condition means the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe

pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected by a reasonable layperson to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions, the presenting symptoms
- Serious dysfunction of any bodily organ or part, or
- Disfigurement to the person

Refer to **Reasonable/Prudent Layperson** definition in this Glossary.

Endorsement means a provision added to the Group Subscriber Agreement that changes its original intent.

Enrollee or Covered Person means a Subscriber, policyholder or Subscriber's enrolled Dependent or Dependents, or other individual participating in a Health Benefits Plan.

Evidence-based Medical Literature means only published reports and articles in authoritative, peer-reviewed medical and scientific literature.

Excluded Services means Healthcare Services that are not Covered Services and that we will not pay for.

Experimental or Investigational medical, surgical, other healthcare procedures or treatments, including drugs. As used in this Agreement, "Experimental" or "Investigational" as related to drugs, devices, medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated does, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by State law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in State law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or

- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

Eye Refraction means the measurement of the degree of refractive error of the eye by an eye care specialist for the determination of a prescription for eyeglasses or contact lenses.

Family, Infant and Toddler (FIT) Program means an early intervention services program provided by the Healthy Family and Children's Healthcare Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

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 physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. For the most up-to-date *formulary* drug information visit **https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101**

Generic Drugs are 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.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental disability 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)
- Disorders of fat metabolism

Good Cause means nonpayment of premium, fraud or a cause for cancellation or a failure to renew which the Superintendent of Insurance of the state of New Mexico has not found to be objectionable by regulation.

Grievance means any expression of dissatisfaction from any Member, the Member's Representative, or a Practitioner/Provider representing a Member.

Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Practitioner/Provider, acting on behalf of that person with that person's consent, entitled to receive healthcare benefits provided by the healthcare plan.

- An individual, or that person's authorized representative, who may be entitled to receive healthcare benefits provided by the healthcare plan.
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Healthcare Purchasing Act.

Group means the legal entity which has contracted with us to obtain the benefits described in this Agreement for Subscribers and eligible Dependents, called Members, in return for periodic Prepayments specified in the Group Letter of Agreement (GLA).

Group Letter of Agreement (GLA) means the administrative agreement between us and the Group.

Group Subscriber Agreement (Agreement) means the booklet which describes the Covered Benefits for which the Member and his/her eligible Dependents (if any) are eligible for under the terms of the employer's Group Contract.

Habilitative Services means services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally.

Health Benefits Plan means a policy or Agreement entered into, offered or issued by a Health Insurance carrier to provide, deliver, arrange for, pay for, or reimburse the costs of Healthcare Services.

Healthcare Facility means an institution providing Healthcare Services, including a Hospital or other licensed Inpatient center; an ambulatory surgical or treatment center; a Skilled Nursing Facility; a Residential Treatment Center, a Home Health Agency; a diagnostic laboratory or imaging center; and a Rehabilitation Facility or other therapeutic health setting.

Healthcare Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit healthcare plan, fraternal benefit society, vision plan, or pre-paid dental plan.

Healthcare Professional means a physician or other healthcare Practitioner, including a pharmacist or Practitioner of the Healing Arts, who is licensed, certified or otherwise authorized by the state to provide Healthcare Services consistent with state law.

Healthcare Services means service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the Health Benefits Plan, a physical or behavioral health service.

Health Maintenance Organization (HMO) means a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It

generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMO's often provide integrated care and focus on prevention and wellness.

Hearing Aid means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

Hearing Officer, Independent Co-Hearing Officer or ICO means a healthcare or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and Coverage issues that arise in external review hearings.

Home Health Agency means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

Home Health Care Services means Healthcare Services provided to a Member confined to the home due to physical illness. Home Health Care Services and home intravenous services and supplies will be provided by a Home Health Agency at a Member's home when prescribed by the Member's Practitioner/Provider and we approve a **Prior Authorization** request for such services.

Hospice means a duly licensed facility or program, which has entered into an agreement with us to provide Healthcare Services to Members who are diagnosed as terminally ill.

Hospital means a facility offering inpatient services, nursing and overnight care for three or more individuals on a **24-hours**-per-day, **7-days**-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

Human Papillomavirus Screening means a test approved by the Federal Food and Drug Administration for detection of the Human Papillomavirus.

Identification Card (ID or Card) means the card issued to a Subscriber (Member) upon our approval of an Application that identifies you as a Covered Member of your Group Health Benefits Plan.

Immunosuppressive Drugs means Prescription Drugs/Medications used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include, but are not limited to:

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e. "autoimmune" diseases)
- Reducing inflammation
- Relieving certain symptoms

- Other times when it may be helpful to suppress the human immune response

Independent Quality Review Organization (IQRO) means an organization independent of the Healthcare Insurer or managed healthcare organization that performs external quality audits of Managed Health Care Plans and submits reports of its findings to both the Healthcare Insurer and the managed healthcare organization and to the Division.

In-network Pharmacy means any duly licensed pharmacy, which has entered into an agreement with us to dispense Prescription drugs/Medications to our Members.

In-network Physician means any licensed Practitioner of the healing arts acting within the scope of his or her license who has entered into an agreement directly with us to provide Healthcare Services to our Members.

In-network Practitioner/Provider means a Practitioner/Provider who, under a contract or through other arrangements with us, has agreed to provide Healthcare Services to Covered Persons, known as Members, with an expectation of receiving payment, other than Cost Sharing Deductibles, Coinsurance and/or Copayments), directly or indirectly from us.

Inpatient means a Member who has been admitted by a healthcare Practitioner/Provider to a Hospital 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. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital. This may also be known as Hospitalization.

Long-term Therapy or Rehabilitation Services means therapies that the Member's Practitioner/Provider, in consultation with us, does not believe will likely result in Significant Improvement within a reasonable number of visits. Long-term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which Rehabilitation Services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome and Cerebral Palsy.

Malocclusion means abnormal growth of the teeth causing improper and imperfect matching.

Managed Care means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for Healthcare Services. Managed Care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services;
- Contracts with selected health care Practitioner/Providers;
- Financial incentives or disincentives for Covered Persons to use specific Practitioners/Providers, services, prescription drugs, or service sites;

- Controlled access to and coordination of healthcare services by a case manager; and
- Payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care

Managed Health Care Plan (MHCP or Plan) means a Health Benefit Plan that we offer as a Healthcare Insurer that provides for the delivery of Comprehensive Basic Healthcare Services and Medically Necessary services to individuals enrolled in the plan (known as Members) through our own contracted healthcare Practitioners/Providers. This Plan either requires a Member to use, or creates incentives, including financial incentives, for a Member to use healthcare Practitioners/Providers that we have under contract. This Plan (Agreement) is considered to be a Managed Health Care Plan.

Maternity Benefits means Covered Benefits for prenatal, intrapartum, perinatal or postpartum care.

Medicaid means Title XIX and/or Title XXI 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 any coinsurance, deductible or amount beyond the annual maximum.

Medical Drugs (Medications obtained through the medical benefit). A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization** and some must be obtained through the specialty network.

Medical Director means a licensed physician in the 5-county area, who oversees our Utilization Management Program and Quality Improvement Program, that monitors access to and appropriate utilization of Healthcare Services and that is responsible for the Covered medical services we provide to you as required by New Mexico law.

Medical Necessity or Medically Necessary means Healthcare Services determined by a Provider, in consultation with the Health Insurance carrier, to be appropriate or necessary, according to:

- any applicable generally accepted principles and practices of good medical care;
- practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
- any applicable clinical protocols or practice guidelines developed by the Health Insurance carrier consistent with such federal, national, and professional practice guidelines. These standards shall be applied to decisions the diagnosis or direct care and treatment of a physical, behavioral health condition, illness, injury, or disease.

Medicare means Title 18 of the Social Security Amendments of 1965, "Health Insurance for Aged and Disabled", as then constituted or later amended.

Member means the Subscriber or Dependent eligible to receive Covered Benefits for Healthcare Services under this Agreement. Also known as an Enrollee.

National Health Care Network means Out-of-network (outside of the 5-county area) Practitioner/Providers, including medical facilities, with whom we have arranged a discount for Healthcare Service(s) provided out-of- state (outside of New Mexico).

Nurse Practitioner means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a Certified Nurse Practitioner pursuant to the Nursing Practice Act.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is Covered only when enteral tube feedings are required.

Observation Services means outpatient services furnished by a Hospital and Practitioner/Provider 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, 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 Practitioner/Providers written order. Our level of care criteria must be met in order to transition from Observation Services to an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient status. Medical criteria will also be considered. Observation for greater than **24 hours** will require **Prior Authorization** by the facility.

Obstetrician/Gynecologist means a Physician who is eligible to be or who is board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Organ means an independent body structure that performs a specific function.

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.

Orthotic Appliance means an external device intended to correct any defect of form or function of the human body.

Out-of-network (outside of the 5-county area) Practitioner/Provider means a healthcare Practitioner/Provider, including medical facilities, who has not entered into an agreement with us to provide Healthcare Services to our Members.

Out-of-network (outside of the 5-county area) Services means Healthcare Services obtained from an Out-of-network (outside of the 5-county area) Practitioner/Provider as defined above.

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Contract Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay 100 percent (**100%**) of the Medicare Allowable. The Annual Out-of-pocket Maximum includes Deductible, Coinsurance, Copayments and Cost Sharing (including **Self-Administered Specialty Drugs**) and does not include non-covered charges including charges incurred after the benefit maximum has been reached.

Over the counter (OTC) means a drug for which a prescription is not normally needed.

Palliative Care means specialized medical care for people with serious illnesses. It is provided by an interdisciplinary team of clinicians and other specialists, who work with the member's other providers to provide an extra layer of support.

Personal Representative means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to healthcare.

PHP means Presbyterian Health Plan, a corporation organized under the laws of the state of New Mexico.

PHP Video Visit means a virtual visit with a contracted Walmart Health Virtual Care provider. These visits are scheduled through the myPRES portal.

PPACA means Patient Protection and Affordable Care Act.

Physician means any licensed Practitioner of the healing arts acting within the scope of his/her license.

Physician Assistant (PA) means a skilled person who is a graduate of a Physician Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Physician Assistants, and who is licensed to practice medicine, usually under the supervision of a licensed Physician.

Practitioner of the Healing Arts means a Healthcare Professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

Practitioner/Provider means any licensed Practitioner of the healing arts acting within the scope of his/her license.

Preferred (as it refers to medication and diabetic supplies) means medication that is selected for inclusion on Preferred tiers of the *Formulary* based on clinical efficacy, safety, and financial value.

Premium means the amount paid for a Contract of health insurance.

Prepayment means the monthly amount of money we charge payable in advance for Covered Benefits provided under this Agreement in accordance with the applicable Group Letter of Agreement (GLA) or non-Group Membership Letter of Agreement.

Prescription Drugs/Medications means those drugs that, by federal law, require a Practitioner's/Provider's prescription for purchase (the original packaging of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend, Caution: Federal law prohibits dispensing without a prescription or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

Primary Care Provider/Physician/Practitioner (PCP) means a Healthcare Professional who, within the scope of the professional license, supervises, coordinates, and provides initial and basic care to Covered Persons; who initiates the patient's referral for specialist care, and who maintains continuity of patient care.

PCPs include General Practitioners, Family Practice Physicians, Geriatricians, Internists, Pediatricians, and Obstetricians / Gynecologists, Physician Assistants and Nurse Practitioners. Other Healthcare Professionals may also **ser**ve as Primary Care Practitioners.

Prior Authorization or Pre-certification means a pre-service determination made by a Health Insurance carrier regarding a Covered Person's eligibility for Healthcare Services based on Medical Necessity, Health Benefits Coverage and the appropriateness and site of service pursuant to the terms of the Health Benefits Plan.

Prosthetic Device means an artificial device to replace a missing part of the body.

Provider means a licensed Healthcare Professional, hospital or other facility authorized to furnish Healthcare Services.

Pulmonary Rehabilitation means a program of therapy designed to improve lung functions.

Reasonable/Prudent Layperson means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Healthcare Services. A Reasonable/Prudent Layperson is considered to have acted "reasonably" if, after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part, or
- Disfigurement to the person

Reconstructive Surgery means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery.
- Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

Registered Lay Midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Rehabilitation Facility means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

Rehabilitation Services means Healthcare Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.

Remitting Agent means the person or entity designated by the Group to collect and remit the Prepayment to us.

Rescission of Coverage means a cancellation or discontinuance of Coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of Coverage has only a prospective effect, or
- The cancellation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums, Prepayments or contributions towards the cost of Coverage.

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available **24 hours** a day.

Screening Mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic Members and includes the X-ray examination of the breast using equipment that is specifically for mammography, including the X-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film but does not include diagnostic mammography.

Self-Administered Specialty Drugs (Tier 5 Medications obtained through the Prescription Drug/Medication pharmacy benefit) Self- Administered Specialty Drugs are self-administered, meaning they are administered by the patient, a family member or caregiver. Self-Administered Specialty Drugs are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Most Self-Administered Specialty Drugs require **Prior Authorization** and must be obtained through the specialty pharmacy network. Self- Administered Specialty Drugs are often high cost, typically greater than **$600** for a **30-day** supply.

For a complete list of these drugs, please see the Health Insurance Exchange Metal Level Plan *Formulary* list at
https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00236101

Service Area means the geographic area in which we are authorized to provide services as a Health Maintenance Organization in the 5-county area of central New Mexico and includes the counties of Bernalillo, Santa Fe, Sandoval, Valencia and Torrance.

Short-term Rehabilitation means Rehabilitation Services and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected. See *Summary of Benefits and Coverage* for the number of visits.

Significant Improvement means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy or
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record.

Skilled Nursing Facility means an institution that is licensed under state law to provide skilled care nursing care services and has entered into an agreement with PHP to provide Covered Services to our Members.

Smoking Cessation Counseling/Program means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up.
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance.
- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Special Medical Foods means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require **Prior Authorization** through Presbyterian's Pharmacy Department.

Specialty Pharmacy – Presbyterian's In-network Pharmacy vendor that, under contract or other arrangement with us, provides *Formulary* **Self- Administered Specialty Drugs** to Members.

Spouse - Legally married husband or wife.

Subluxation (Chiropractic) means misalignment, demonstrable by x-ray or Chiropractic examination, which produces pain and is correctable by manual manipulation.

Subscriber means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the Health Benefits Plan, or in the case of an individual Contract, the Person in whose name the Contract is issued.

Substance Use Disorder means dependence on or abuse of substances meeting the criteria as stated in the DSM-5 for these disorders.

Summary of Benefits means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective Subscriber or Covered Person by the Health Insurance carrier.

Superintendent means The Superintendent of Insurance, the Office of the Superintendent of Insurance (OSI), or employees of OSI acting with the Superintendent's authorization.

Surprise Bill is an unexpected bill from a healthcare provider or facility. This can happen when a person with health insurance unknowingly gets medical care from a provider or air ambulance services outside their health plan's network. Surprise billing happens in both emergency and non-emergency care settings.

Telemedicine means the use of telecommunications and information technology to provide clinical health care from a distance. Telemedicine allows healthcare professionals to evaluate, diagnosis and treat patients in using telecommunications and technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver healthcare services to a site where the patient is located, along with the use of electronic media and health information. Telemedicine allows patients to access medical expertise without travel.

Temporomandibular Joint (TMJ) is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

Termination of Coverage means the cancellation or non-renewal of Coverage provided by a Healthcare Insurer to a Covered Person/Grievant but does not include a voluntary termination by a Covered Person/Grievant or termination of the Health Benefits Plan that does not contain a renewal provision.

Tertiary Care Facility means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Tobacco means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas, and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and betel nut), and novel Tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

Total Allowable Charges means, for In-network Practitioner/Providers, the Total Allowable Charges may not exceed the amount the Practitioner/Provider has agreed to accept from us for a Covered service. For Out-of-network (outside of the 5-county area) Practitioner/Providers, the Total Allowable Charges may not exceed Medicare Allowable Charge as we determine for a service.

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered Persons/Grievants to utilize preferred (In-network) Practitioners/Providers, to follow pre-authorization (**Prior**

Authorization) rules, to utilize Prescription Drug Formularies or other cost-saving procedures to obtain Prescription Drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by a Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify/authorize or deny a requested Healthcare Service.

Urgent Care Situation means a situation in which a Prudent Layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

- The life or health of the Covered Person would otherwise be jeopardized;
- The Covered Person's ability to regain maximum function would otherwise be jeopardized;
- In the opinion of a physician with knowledge of the Covered Person's medical condition, delay would subject the Covered Person to severe pain that cannot be adequately managed without care or treatment;
- The medical exigencies of the case require expedited care; or
- The Covered Person's claim otherwise involves urgent care.

Urgent Care Center means a facility operated to provide Healthcare Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Utilization Review means a system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

Vocational Rehabilitation means services which are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

Well-child Care means routine pediatric care 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.

Women's Healthcare Practitioner/Provider means any Practitioner/Provider who specializes in Women's Healthcare and who we recognize as a Women's Healthcare Practitioner/Provider.

This Group Subscriber Agreement is issued to the Group for the Subscriber named in an Application received and accepted by Presbyterian Health Plan, a New Mexico corporation. The terms and conditions appearing herein, and any applicable amendments are part of this Group Subscriber Agreement.

IN WITNESS THEREOF, Presbyterian Health Plan has caused this Group Subscriber Agreement to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN

Brandon Fryar
President
Presbyterian Health Plan, Inc

Exhibit A – Statement of ERISA Rights

The Group healthcare Coverage provided by your employer may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The statement of ERISA rights is applicable to all Group plans except governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens.

If applicable, as a participant in your employer's Group healthcare plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to:

Article I. Receive Information about your Plan and Plan Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Section 1.01 Continue Group Health Plan Coverage

- Continue healthcare Coverage for yourself, Spouse or Dependents if there is a loss of Coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such Coverage.
- Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Article II. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining healthcare benefits or exercising your rights under ERISA.

Section 2.01 Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within **30 days**, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **$110** a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Section 2.02 Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa**, or at the Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210 or contact the U.S. Department of Health and Human Services at **1-877-696-6775** or **www.cciio.cms.gov**. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272**.

Notice of Nondiscrimination and Accessibility
Discrimination is Against the Law

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with use, such as:
    - Qualified sign language interpreters
    - 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
    - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-7521, 1-855-923-7521, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-5124, or **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

You can also file a complaint with these state agencies:

Address: Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta
Santa Fe, NM 87501

Phone: (505) 827-3811 or toll-free 1-**833-415-0566**

Online:* **www.osi.state.nm.us**

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Address: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Phone: (505) 490-4060 or toll-free 1-844-255-9210

Fax: (505) 490-4883

*To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit **https://www.nmag.gov/consumer-complaint-instructions.aspx**.

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:

Address: U.S. Department of Health and Human Services200
Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Aviso de no discriminación y accesibilidad
La ley prohíbe la discriminación

Presbyterian Healthcare Services se compromete a prestar servicios de atención médica equitativos y existe con el fin de mejorar la salud de los pacientes, de los asegurados y de las comunidades que servimos. Valoramos la diversidad y la inclusión y nos esforzamos por tratar a todos con respeto. No discriminamos por motivos de raza; color; linaje; origen nacional (incluso por dominio limitado del inglés); ciudadanía; religión; sexo (incluso por embarazos, partos o problemas médicos conexos); estado civil; orientación sexual; expresión o identidad de género; estado de veterano; estado militar; estado de ausencia familiar o médica; edad; discapacidad física o mental; estado médico; datos genéticos; capacidad de pago; o cualquier otro estado protegido. Presbyterian proporcionará adaptaciones razonables y servicios de acceso al idioma a nuestros pacientes, asegurados y fuerza laboral.

Presbyterian Healthcare Services:

- Presta servicios y ayuda a las personas con discapacidades para que se puedan comunicar efectivamente, por ejemplo:
    - Intérpretes calificados de lengua de señas
    - Información escrita en otros formatos (letra grande, grabaciones de audio, formatos electrónicos accesibles y otros formatos)
- Proporciona servicios gratuitos de acceso al idioma a las personas cuyo idioma principal no es inglés, por ejemplo:
    - Intérpretes calificados
    - Información escrita en otros idiomas

Si necesita alguno de esos servicios, llame al Centro de Servicio al Cliente de Presbyterian al (505) 923-7521, 1-855-923-7521, TTY 711.

Si cree que Presbyterian Healthcare Services no le ha proporcionado dichos servicios o si cree que le han discriminado de alguna otra manera, puede presentar una reclamación a Presbyterian si llama al 1-866-977-3021, TTY 711, fax (505) 923-5124, o **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

Además puede presentar una queja formal referente a los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. electrónicamente en el portal de quejas de la Oficina de Derechos Civiles, que está a su disposición en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** o por correo o por teléfono al:

Además puede presentar queja a las agencias estatales siguientes:

Dirección: Managed Health Care Bureau
[Oficina de Atención Médica Administrada]
Office of Superintendent of Insurance
[Oficina del Superintendente de Seguros]
1120 Paseo De Peralta

PRESBYTERIAN

Santa Fe, NM 87501

Teléfono: (505) 827-3811 o gratis al 1-**833-415-0566**

En línea:* **www.osi.state.nm.us**

Dirección: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Teléfono: (505) 490-4060 o gratis al 1-844-255-9210

Fax: (505) 490-4883

*Para llenar el Formulario de Queja del Consumidor o para bajar el formulario a su computadora, ya sea en inglés o español, visite **https://www.nmag.gov/consumer-complaint-instructions.aspx**.

Dirección: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Número de teléfono (gratuito): 1-800-368-1019, 800-537-7697 (TDD)

Los formularios de quejas están a su disposición en **http://www.hhs.gov/**.

Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíilnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420، 1-855-592-7737 رقم هاتف الصم والبكم (TTY: 711).
Korean	주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오 .
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

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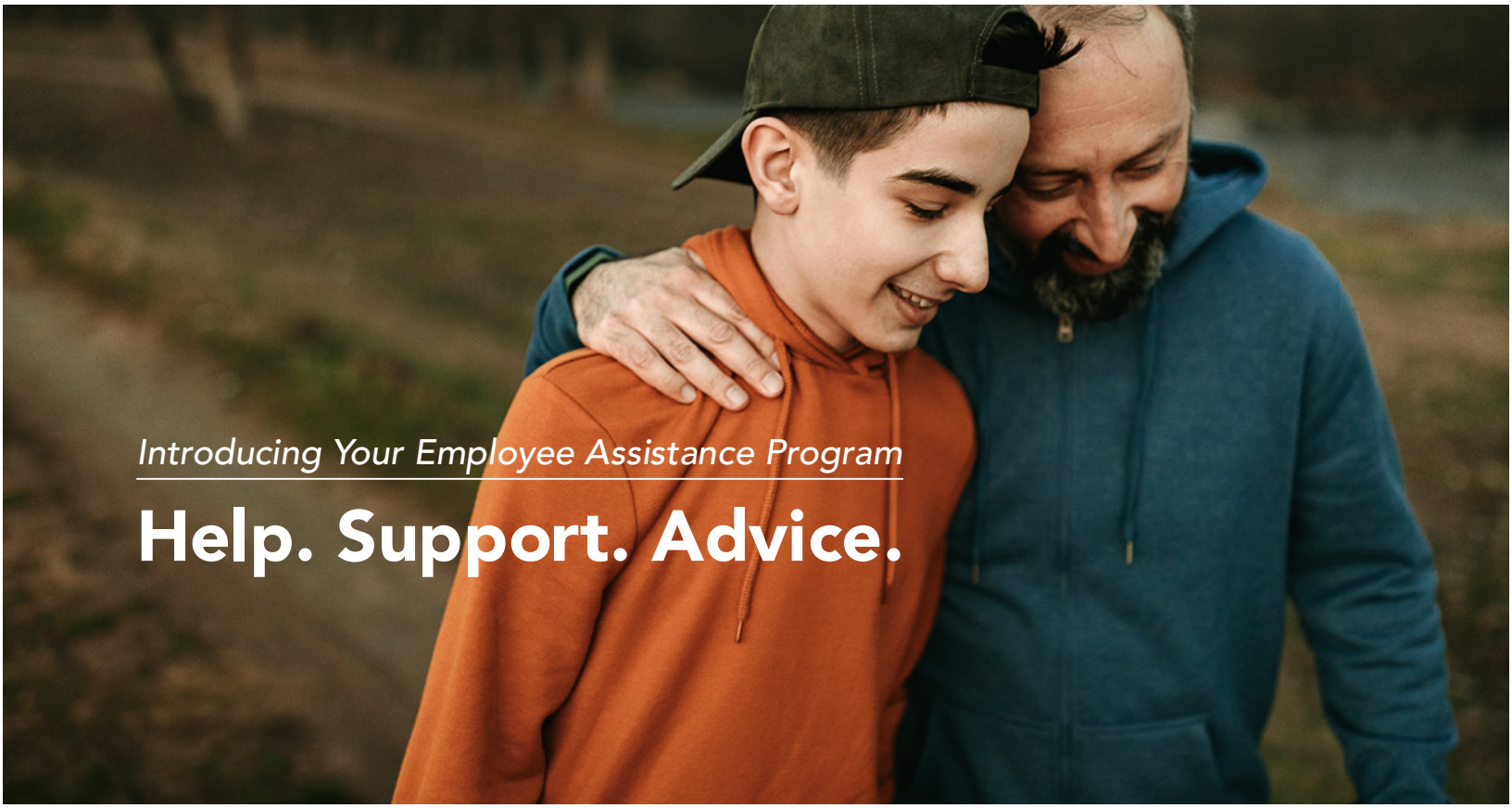

Introducing Your Employee Assistance Program

Help. Support. Advice.

If you or your loved ones face difficult situations like stress, relationship challenges, grief, loss or substance use, we're here to help. Learning how to cope with these issues can improve your overall well-being.

You and your household members can get up to six employee assistance visits per issue through The Solutions Group, a division of Presbyterian Healthcare Services.

Employee Assistance Program (EAP) services are short-term, confidential counseling sessions conducted by local licensed providers and can include:

- mediation services
- substance use assessments and referrals
- 24-hour emergency services
- support for supervisors and managers
- referrals for additional support

When faced with complex personal or work-related challenges, let our EAP providers help. To schedule an appointment with an EAP counselor or for after-hours crisis support, please call 1-866-254-3555 or (505) 254-3555.

Services provided by:

The Solutions Group

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Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

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PHP-148 0421

Presbyterian Video Visits

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Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Need to see a provider right now? Seeing a medical provider for your non-urgent medical questions just got a whole lot easier, more convenient, and affordable. When your primary care provider (PCP) isn't available, talk with a medical provider day or night using your smartphone, tablet, or computer webcam. And for ***most*** Presbyterian Health Plan members, this service is at no cost. Some plans require a small copay. For high deductible health plan (HDHP) members, the applicable copay or coinsurance will apply until you meet your deductible. Please see your plan details for more information.

Presbyterian Video Visit providers cannot prescribe narcotics or lifestyle medications. Please talk with your Presbyterian medical provider for these types of medications.

How it works

Do I need a myPRES account to use Video Visits?
Yes, you can only use Video Visits through your myPRES account.

What happens after I log in to see a provider?
You will need to fill out a medical history questionnaire before your first Video Visit consultation. You'll only fill this out once unless you need to update your medical history. After you fill out the history questionnaire and request a Video Visit, you must speak to a representative to have a Video Visit. Our representative will call you to help connect you to a provider.

Do I have to log in or register if I want my child or dependent to have a Video Visit?
The names of your dependents will appear when you log in so that you can select who needs the visit. You will also need to be present during the visit if your child or dependent is under the age of 18.

What if I registered for myPRES but I can't remember my user ID or password?
You can follow the steps to reset your password or have your user ID emailed to you. If you still have issues with your login, please call (505) 923-5590 or toll-free 1-866-861-7444.

What languages are offered?
You can search and choose a provider to have your Video Visit in English or in Spanish. If you need help in another language, please call the Presbyterian Video Visits dedicated line toll-free at 1-844-SEE-PRES or 1-844-733-7737.

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PHP-7 0220

Schedule a Video Visit via myPRES

Step 1: Log in to myPRES

Go to www.phs.org and select Access MyHealthPlan. Under Options for Care, select **Video Visits**.

Need a myPRES account? Sign up at **www.phs.org**.

Step 2: Sign up for a Video Visit Account

Fill out a medical history questionnaire. It's quick and easy, and we'll walk you through each step.

TIPS:

- Fill out this form now so you're ready to go should you need to schedule a Video Visit later.
- See Technical Support at **www.phs.org/videovisits** for technical requirements.

Step 3: Schedule Your Video Visit

You will need to enter your symptoms. You will also need to enter your payment information if you are on a high deductible health plan (HDHP). A care coordinator will call you after you schedule a visit and place you into the waiting room queue.

Step 4: Your Visit

Within 30 minutes or less, you will connect with a medical provider. He or she will ask you to describe your medical issue, offer a diagnosis and medical advice, and send a prescription to your pharmacy if it's needed.

Step 5: Get Your Visit Summary

You will get a text or an email after your visit, prompting you to download your visit summary. Return to your Presbyterian Video Visit profile account via myPRES anytime to review past medical information.

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www.phs.org

Presbyterian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (505) 923-5420, 1-855-592-7737 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

Give Your Employees the Flexibility and Convenience of Virtual Care

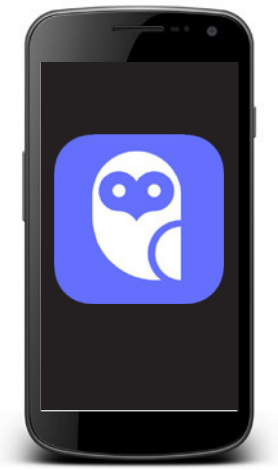
Increasing access to health care with TytoHome™.

Now your employees* can have a comprehensive medical exam and telehealth visit remotely from the comfort of home or anywhere else through TytoCare.

TytoHome is a handheld exam kit and app that lets the patient perform guided medical exams with a licensed provider. It's just like a clinic visit, except it's virtual. Employees can skip the waiting room when they don't feel well and use TytoCare to connect with a provider for an assessment.

The kit is a home device that includes a camera for taking photos and videos of the skin and the throat, an infrared thermometer for taking temperature, an otoscope for looking inside the ears, and a stethoscope for capturing heart, lung and abdomen sounds and heart rate.

With these tools a provider can remotely replicate the exams performed during an in-office exam by receiving body temperature, high quality digital sounds of the heart and lungs, and digital images and video of the ears, throat and skin. Patients can get a diagnosis and treatment plan for common conditions like allergies, sore throat, rashes, sinus pain and flu, just to name a few.



After downloading the TytoCare app on their iOS or Android device, members can create an appointment and launch a virtual visit through their Presbyterian MyChart account.

** The TytoCare kit and virtual exams are available at no cost for employees of select employer groups who are enrolled in any Presbyterian health plan. The TytoCare platform is HIPAA-compliant and all data is encrypted. All devices comply with FDA requirements.*

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Presbyterian Insurance Company, Inc.

tytocare™

MPC052207

Not only is TytoCare convenient, it offers a more comprehensive medical exam than a typical virtual visit.

The enhanced health data collected elevates the patient and provider experience which can improve patient outcomes.

Clinical Data	With TytoCare	With Virtual Alone
Heart Rate	✔	
Heart Sounds	✔	
Lung Sounds	✔	
Bowel Sounds	✔	
Abdominal Sounds	✔	
Throat Visual	✔	
Ear Visual	✔	
Skin Visual	✔	
Patient Affect	✔	✔

How TytoCare Drives Health Care Savings[1]

- ED diversion — 40.5%
- ROI[2] — 18–30X
- Visits resolved *(fully remotely with no in-person encounters)* — 98%

1 TytoCare, 2021 Internal Business Impact Report

2 Assumes a cost of $1632 per ED visit, $180-300/year per Tyto bundle (range of connector options). Study included 1000 households (each with 1 device).

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Presbyterian Insurance Company, Inc.

tytocare™