PRESBYTERIAN

Presbyterian Health Plan, Inc.

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

County of Bernalillo

Offered by the County of Bernalillo
Administered by Presbyterian Health Plan

County of Bernalillo
PPO Plans
MPC112241

07/01/2022

WELCOME

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

Our medical plans are self-insured. This means the County of Bernalillo is responsible for the design of the plan and the setting of contributions. We set the contribution rates to be adequate to pay for the claims we all incur. When our claims exceed the contributions, the contribution rates have to go up.

All medical plans offer no cost In-Network preventive care. Please take advantage of this benefit after you enroll. Early diagnosis plays a big part in the eventual outcome of any health condition.

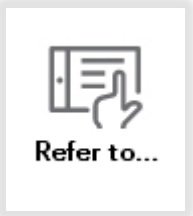
This booklet is intended to provide you with an easy-to-understand explanation of the Plan effective July 1, 2022. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this booklet and the claims administrative procedures of our Third-Party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

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

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

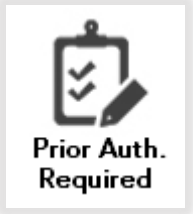
UNDERSTANDING THIS SUMMARY PLAN DESCRIPTION

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



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

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



Prior Authorization Required – This "Prior Authorization" symbol will appear next to those Covered Benefits that require our Authorization (approval) in advance of those services. To receive full benefits, your In-network Provider must call us and obtain Authorization before you receive treatment. You must call us if you are seeking services Out-of-network. In the case of a Hospital In-patient Admission following an Emergency Room visit, you or your Provider 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 if there are no Covered Benefits when your receive care Out-of-network.

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 SPD and the *Summary of Benefits and Coverage* will be capitalized. These terms are defined in the Glossary of Terms Section.

INTRODUCTION

The County of Bernalillo provides group healthcare coverage through the Preferred Provider Organization (PPO) Medical Plan (Plan) administered by Presbyterian Health Plan, Inc.

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

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

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

This PPO Plan allows you to choose, at the time you receive services, the level of benefits that will apply. You receive the highest benefit level with the lowest cost to you when you obtain services from a Preferred Provider. The Presbyterian Health Plan Provider Directory lists the Preferred Providers. The Provider Directory is available through the Presbyterian Health Plan website at **www.phs.org**, or you can obtain one by contacting our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. **(TTY: 711)**.

Additionally, Presbyterian Health Plan now contracts with National PPO Network Provider, a National Preferred Provider organization with over 3,500 acute care Hospitals and 400,000 Providers. If you live or are traveling outside the State of New Mexico, and require medical attention, we encourage you to see National PPO Network Providers and facilities. National PPO Network Providers provide care to Presbyterian Health Plan Members at discounted rates, which help keep the cost of Medical Care down. Additionally, you cannot be charged for any difference between what Presbyterian Health Plan pays the Provider and what the Provider charges beyond your appropriate Copayment and/or Deductible and Coinsurance (see "How the Plan Works" Section). The National PPO Network Provider Directory is available through their website at **https://www.multiplan.com/** or you can contact the Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219**. **(TTY: 711)**.

Please take the time to read this booklet carefully before placing it in a safe place for future reference. If you have any questions regarding this booklet, please call our Presbyterian

Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at (**505) 923-5678**, or **1-800-356-2219**. **(TTY: 711)**. It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

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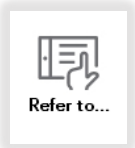
HOW THE PLAN WORKS

Your Group healthcare plan is a Preferred Provider Organization (PPO) Plan whereby you obtain all routine Covered Services from In-network Providers within the Presbyterian Health Plan (PHP) Provider network or from our National Network Providers outside of New Mexico.

IN-NETWORK PROVIDERS

You may choose an In-network Primary Care Provider (PCP) to coordinate your care. In-network PCPs are Providers who have a contract with PHP to provide, coordinate and manage your healthcare needs. In-network PCPs include family and general practice, internal medicine and pediatric Providers who are conveniently located throughout the PPO network area. When you see an In-network PCP or any other In-network Provider, you pay a Deductible and/or Copayment for most services. The In-network Provider handles any necessary **Prior Authorizations** for you.



In-network OB/GYNs can be seen. This benefit, called Open Access, allows female Members to see their OB/GYN for care related to pregnancy or any gynecological condition.

If you want to know more about your In-network Provider, the Presbyterian Customer Service Center (PCSC) can tell you information such as medical school attended, residency completed and board certification status.

NATIONAL NETWORK PROVIDER

You can also obtain Covered Services outside of New Mexico from MultiPlan/Private Health Care Systems PPO Providers (MP/PHCS). Your Deductible, Copayment and/or Coinsurance will be the same as if you received the services from an In-network Provider. You can contact a Presbyterian Customer Service Center representative to help you locate an out-of-state MP/PHCS Provider. However, MP/PHCS Providers are not considered “In-network Providers”. If a Covered Service requires **Prior Authorization**, you are responsible for obtaining that **Prior Authorization** before obtaining that covered service from a MP/PHCS Provider. If you fail to obtain **Prior Authorization** when required, you will be responsible for Copayments, Deductibles and/or Coinsurance as listed in the *Summary of Benefits*.

You will not have any claims to file or papers to fill out in order to be reimbursed for medical services obtained from In-network Providers and an out-of-state MP/PHCS Providers. Your In-network Provider or out-of-state MP/PHCS Provider will bill us directly. Most Provider visits and Hospital Admissions however, do require Copayment at the time of service. The amount of your Copayment for each service can be found in the *Summary of Benefits*.

OUT-OF-NETWORK PROVIDERS

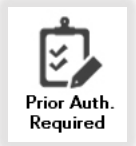
Out-of-network Providers are those Providers that are not part of the PHP Provider Network and are not an out-of-state National Network Provider. Services provided by Out-of-network Providers other than in Out-of-network Student Health Centers, and except for injury, urgent or emergency care, are excluded under this Plan.

HOW TO ACCESS CARE

Though not required, it is highly recommended that you select an In-network PCP to coordinate your healthcare needs. Your In-network PCP will be able to meet most of your healthcare needs. A list of In-network PCPs can be found in the PHP Provider Directory or on the PHP website at **www.phs.org**. You may choose any Provider, nurse practitioner or physician assistant on that list as your In-network PCP. If you choose an In-network PCP from this list and notify Presbyterian Health Plan of your selection, that PCP information will appear on your ID Card.

You may choose to obtain PCP services from an out-of-state National Network Provider. If you chose this option, no PCP data will appear on your ID Card. If you decide to obtain PCP services from an out-of-state National Network Provider, you will have to manage more of your healthcare. National Network Provider are not required to utilize In-network Providers, In-network Hospitals or facilities or other out-of-state National Network Provider or facilities for laboratory tests, x-rays or any other Covered Service. Therefore, if you choose to obtain services from a National Network Provider and they request laboratory tests, x-rays, etc., or refer you to another Provider/Specialist, it is your responsibility to ensure the Provider or facility providing Covered Services is an In-network or an out-of-state National Network Provider or facility. Otherwise, the services may not be covered and your claim may be denied.

WHAT IS PRIOR AUTHORIZATION?



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

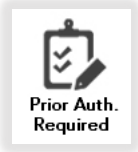
The **Prior Authorization** requirements affect whether the Plan pays for your Covered Services. However, **Prior Authorization** does not deny your right to be admitted to any Hospital.
you make the best use of your Covered Benefits. You should keep this Summary Plan

IMPORTANT: If you have Coverage that includes Dependent or Family Medical Coverage, **Prior Authorization** requirements apply to your family members who are also covered persons.

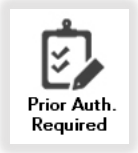
WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION?

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

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



PRIOR AUTHORIZATION – INPATIENT



If your In-network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, your In-network Provider is responsible for any **Prior Authorization** requirement for Inpatient Admissions. If an Out-of-network Provider or National Network Provider recommends you be admitted as an Inpatient to a Hospital or treatment facility, you are responsible for any **Prior Authorization** requirement for Inpatient Admissions. If **Prior Authorization** is not obtained, the Member will be responsible for Copayments, Deductibles and/or Coinsurance as listed in the *Summary of Benefits*.

If Presbyterian Health Plan determines that the Admission was for a Covered Service but hospitalization was not Medically Necessary, **no** benefits are paid for Inpatient room and board charges and these expenses do **not** apply toward the Out-of-pocket Maximum. Other Covered Services are paid as explained in the *Summary of Benefits* and in the Covered Services Section. If the Admission is not for a Covered Service, **no** payment is made.

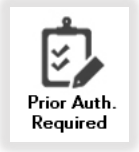
Note:
All Admissions for Behavioral Health and Alcohol and/or substance use disorder services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department (**1-800-453-4347**). If **Prior Authorization** is not obtained, services may not be covered if they do not fall within the benefits and limitations of this Plan. For emergencies, Presbyterian Health Plan Behavioral Health Department must be notified by the end of the next business day or as soon as reasonably possible or benefits may be denied.

Prior Authorization procedures also apply in the event you are transferred from one facility to another, you are readmitted, or when a newborn child remains hospitalized after the mother is discharged.

PRIOR AUTHORIZATION – OTHER MEDICAL SERVICES

Prior Authorization requirements are subject to change at the discretion of Presbyterian Health Plan with the approval of the County of Bernalillo. Contact our Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or toll-free at **1-800-356-2219 (TTY: 711)** to verify services requiring **Prior Authorization**.

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



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

CASE MANAGEMENT PROGRAM

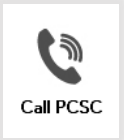
Presbyterian Health Plan's Case Management Program is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive hospitalization, or have complicated discharge planning needs so that cost-effective alternative care arrangements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

FEDERAL AND STATE HEALTHCARE REFORM

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

TRANSITION OF CARE

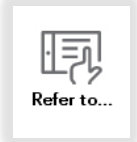
If you are a new Member and are in an ongoing course of treatment with an Out-of-network Provider, you will be allowed to continue receiving care from this Provider for a transitional period of time (usually not to exceed 90 days). Similarly, if you are in an ongoing course of treatment with an In-network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



COST SHARING FEATURES

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

COPAYMENT



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

PLAN YEAR DEDUCTIBLE (JULY 1 – JUNE 30)

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

For Single Coverage, the annual Plan Year Deductible requirement is fulfilled when one Member meets the Individual Deductible listed in the *Summary of Benefits and Coverage*.

For Double Coverage, the Annual Plan Year Deductible requirement is fulfilled when both Members each meet their Individual Deductible listed in the *Summary of Benefits and Coverage*.

For Family Coverage, with three or more enrolled Members, the entire family Deductible must be met before benefits will be paid for the family. However, if one (family) Member reaches the individual Deductible amount before the family has met the Family Deductible, the Plan will begin paying benefits for that Member who has met the Individual Deductible. The family and individual Deductible amounts are listed in the *Summary of Benefits and Coverage*.

Charges for the In-network Provider services are applied to the Out-of-network Deductible (until the In-network Provider Deductible is met) and vice versa.

COINSURANCE

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

OUT-OF-POCKET MAXIMUM

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

The Plan Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits*. Penalty amounts, non-covered charges and any amounts over Medicare Allowable Amounts are not included in the 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%. However, if one (family) Member reaches the Individual Out-of-pocket Maximum amount before the family has met the Family Out-of-pocket Maximum benefits will be paid at 100% for that Member who has met the Individual Out-of-pocket Maximum. The Family and Individual Out-of-pocket Maximums amounts are listed in the *Summary of Benefits and Coverage*.

The Out-of-pocket Maximum includes all medical Cost-sharing (Copayment and Coinsurance) amounts.

MAXIMUM BENEFITS

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

MEDICALLY NECESSARY SERVICES

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

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

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

HEALTHCARE FRAUD MESSAGE

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

- Be wary of offers to "waive Copayments, Deductibles or Coinsurance." These costs are passed on to you eventually.
- Be wary of "mobile health testing labs." Ask how much the insurance company will be charged for the tests.
- Always review the explanation of benefits (EOB) you receive from Presbyterian Health Plan. If there are any discrepancies, call one of our PCSC representatives.

- Be very cautious about giving information about your insurance coverage over the telephone.

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

ELIGIBILITY ENROLLMENT, EFFECTIVE AND TERMINATION DATES

EMPLOYEE ELIGIBILITY

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

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

DEPENDENT ELIGIBILITY

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

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

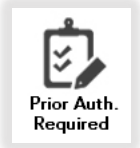
- An eligible employee's lawful spouse may be enrolled as a Dependent after presenting a marriage certificate or other documentation which establishes that the couple entered into a valid common-law marriage in another jurisdiction.
    - An eligible employee's domestic partner may be enrolled as a Dependent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

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

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

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

- If the Dependent attends school in any Presbyterian Health Plan Service Area, services may either be received through the Primary Care Provider or at the Student Health Center.
- If the Dependent is eligible for coverage under this Plan as the result of a court order and the Dependent does not live within the Service Area:
    - You or the covered Dependent is responsible for obtaining any required **Prior Authorizations** from the Plan. If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan. If you obtain services from an Out-of-network MP/PHCS Provider, then it is your responsibility to obtain **Prior Authorization**. Failure to do so will result in benefits being denied or responsibility for any Copayment, Deductible and/or Coinsurance amounts listed on the *Summary of Benefits*.



    - Medically Necessary Covered Services provided by Out-of-network Providers will be reimbursed less the appropriate Copayment up to the Medicare Allowable Amounts. You and/or your Dependent will be responsible for paying any amounts over Medicare Allowable Amounts or for services **not covered** under this Plan.

During initial enrollment, you must provide proof of incapacity and dependency to your agency group representative. Thereafter, proof of incapacity and dependency may be requested periodically by the Claim Administrator.

Benefits are **not** provided for Hospital room and board or Inpatient Provider care for any Hospital Admission or portion of an Admission that is for a Member who is **not covered** or who, at the beginning of the Admission was **not** a Member, an eligible Dependent or the natural-born child of an employee.

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

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

ENROLLING FOR COVERAGE

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

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

HOW TO ENROLL DEPENDENTS

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

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

WHEN COVERAGE STARTS

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

Contact your agency group representative for further details.

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

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

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

CHANGING YOUR COVERAGE

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

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

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

FAMILY STATUS OR EMPLOYMENT STATUS CHANGES (QUALIFYING EVENTS)

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

enrollment. The following family/employment status changes are recognized by the County of Bernalillo:

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

SPECIAL ENROLLMENT/NOTICE OF EMPLOYEE RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you are declining enrollment for yourself or your Dependents (including your spouse and eligible children) because of other group health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan. You must request enrollment within 31 days after you or an eligible Dependent loses coverage under another group health plan either because:

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

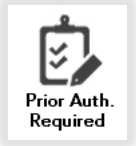
In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

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

ID CARD

Your Plan ID Card identifies the cardholder and your Preferred Provider Organization coverage. Carry it with you.

When you present your card to In-network Providers, they know that you receive special benefits – they will file claims for you and will obtain any needed pre-Admission review or other **Prior Authorizations**. You are responsible for any Copayments, Coinsurance or expenses for non-Covered Services.



Your Member identification number and your group number are on your ID Card. Each of your Dependents will also receive an ID Card. If you or your Dependents selected an In-network Primary Care Provider (PCP), their In-network PCP selection and the PCP's telephone number will also be displayed. (If you or your Dependent(s) did not select an In-network PCP, then no PCP information will be listed on the ID Card.) The reverse side of your ID Card provides the address for Presbyterian Health Plan and some important telephone numbers for your use while using the Plan. It is important that you always show each individual's own ID Card when obtaining care.

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

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

TERMINATION

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

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

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

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

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

- The parent employee becomes entitled to Medicare.

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

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

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

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

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

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

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

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

COBRA AND THE FAMILY AND MEDICIAL LEAVE ACT (FMLA)

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

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

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

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

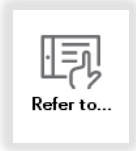
COVERED SERVICES

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

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

ACCIDENTAL INJURY/MEDICAL EMERGENCY CARE/URGENT CARE

MEDICAL EMERGENCY CARE



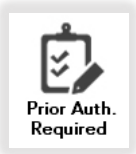
Treatment for a medical emergency or Accidental Injury in the Emergency Room of a Hospital or an Urgent Care facility is a benefit. No notification to Presbyterian Health Plan (PHP) is required. Please refer to the *Summary of Benefits* for Emergency Room visit or Urgent Care Center Copayments and/or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

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

Examples of a medical emergency include but are not limited to a heart attack, poisoning, severe allergic reaction, convulsions, unconsciousness or uncontrolled bleeding.

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

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



No notification or **Prior Authorization** is required for Out-of-network (including out-of-state) Hospitals or treatment facilities for medical emergency services. However, the Member will be responsible for the Copayment and/or Deductible and Coinsurance as outlined on the *Summary of Benefits*, as well as those charges above Medicare Allowable Amounts, for emergency care obtained Out-of-network.

Coverage for trauma services and all other emergency services will continue at least until the Member is medically stable, does not require critical care and can be safely transferred to another facility based on the judgment of the Attending Provider in consultation with Presbyterian Health Plan. Presbyterian Health Plan (PHP) may require that the Member be transferred to a Hospital participating in its Provider network, if the patient is stabilized and the transfer can be completed in accordance with federal law.

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

URGENT CARE

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

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

ACUPUNCTURE SERVICES

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

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

AMBULANCE SERVICES

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

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

A *tertiary care facility* is a Hospital unit that provides highly specialized Medical Care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical providers in state-of-the-art facilities.

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

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

AUTISM SPECTRUM DISORDER

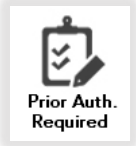
The diagnosis and treatment for Autism Spectrum Disorder is covered in accordance with the state mandate as follows:

- 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.

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

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

BEHAVIORAL HEALTH AND ALCOHOL AND/OR SUBSTANCE USE DISORDER



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

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

Outpatient services are available from the following credentialed Providers:

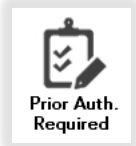
- Medical Doctors, Board Eligible or Board Certified in Psychiatry (M.D.);
- Licensed Psychologists (L.P.);
- Licensed Independent Social Workers (L.I.S.W.);
- Licensed Clinical Mental Health Counselors (L.P.C.C.);
- Licensed Marriage and Family Therapists (L.M.F.T.);
- Clinical Nurse Specialists (C.N.S.);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

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

BEHAVIORAL HEALTH SERVICES

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

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



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

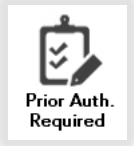
Outpatient, non-Hospital based short-term evaluative and therapeutic Behavioral Health Services will be provided based on medical necessity.

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

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

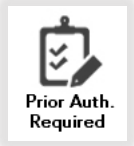
ALCOHOL AND/OR SUBSTANCE USE DISORDERSERVICES

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

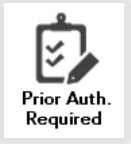


If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required. If you obtain services from a National Network Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain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

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



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



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

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

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

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

BIOFEEDBACK

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

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

CLINICAL TRIALS

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

A **qualified individual** is someone who is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to 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 Health Care Research and Quality;
    d. The Centers for Medicare & Medicaid Services;
    e. A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; OR
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the Secretary of Health and Human Services determines that the study has been reviewed and approved through a system of peer review that (i) is comparable to the system of peer review of studies and investigations used by the National Institutes of Health and (ii) assures unbiased review of the heist scientific standards by qualified individuals who have no interest in the outcome of the review.

Routine patient care costs are covered are items or services that would be covered for a Member or beneficiary who is not enrolled in a Clinical Trial. All applicable Plan limitations for coverage of Out-of-network care will still apply to routine patient costs in Clinical Trials.

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

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

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

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

CARDIAC/PULMONARY REHABILITATION

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

CHEMOTHERAPY/DIALYSIS/RADIATION THERAPY

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

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

CHIROPRACTIC SERVICES

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

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

DENTAL CARE AND MEDICAL CONDITIONS OF THE MOUTH AND JAW

DENTAL ACCIDENTS

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

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

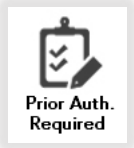
To be covered, *initial* treatment for the injury must be sought within 72 hours of the accident. All covered treatments for dental trauma must be completed within one year of the specific traumatic

injury. If craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are a result of trauma such as a bodily injury or blow caused solely through external, violent and unforeseen means, benefits are available for diagnostic examination, x-rays, medications, physical therapy, dental splints, Acupuncture, orthodontic appliances and treatment, crowns, bridges and dentures. Trauma does not include injury because of biting, chewing or malocclusion.

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

HOSPITALIZATION FOR DENTAL CARE

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

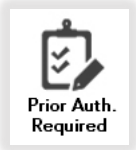


If a Member is admitted for care, **Prior Authorization** is required. If **Prior Authorization** is not obtained, the Member will be responsible for Copayments, Deductibles and/or Coinsurance as listed in the *Summary of Benefits*. In-network Providers will request Prior Authorizations for you. If you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

ORAL SURGERY AND TMJ TREATMENT

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

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



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

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

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

DIABETES SERVICES

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

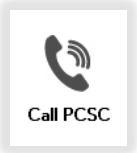
Covered Benefits are provided if you have insulin Dependent (Type I) diabetes, non-insulin Dependent (Type 2) diabetes and elevated blood glucose levels induced by pregnancy (gestational diabetes). We will guarantee Coverage for the equipment, appliances, Prescription Drug/Medications, insulin or supplies 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 Provider who is approved to provide diabetes education:

- Medically Necessary visits upon the diagnosis of diabetes
- Visits following a 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 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 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 Provider and when obtained through the designated network Provider. The following items require the use of approved brands and must be purchased at a preferred vendor or preferred Durable Medical Equipment (DME) supplier. Please contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219. (TTY: 711)**. You may also visit their website at **www.phs.org** for further information.

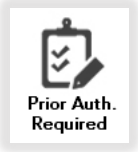


- Insulin pumps when Medically Necessary, prescribed by an In-network endocrinologist
- Specialized monitors/meters for the legally blind
- Medically Necessary Covered Podiatric appliances for prevention of feet complications associated with diabetes. Refer to the **Durable Medical Equipment Benefits 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
- Lancets and lancet devices
- Visual reading urine and ketone strips

DIAGNOSTIC SERVICES

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

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



- CT scans.

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

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

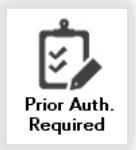
DURABLE MEDICAL EQUIPMENT AND APPLIANCES, HEARING AIDS, MEDICAL SUPPLIES, ORTHOTICS, AND PROSTHETICS

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

- The rental or, at the option of Presbyterian Health Plan, the purchase of Durable Medical Equipment when prescribed by a Provider and required for therapeutic use, including Wheelchairs, Hospital beds, crutches and other necessary Durable Medical Equipment;
- Purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity;
- Prosthetic eyes;
- dental prosthodontic appliances applicable to dental injuries only;
- Breast Prosthetics when required as the result of a mastectomy;
- Orthotic (a rigid or semi-rigid supportive device) or Orthopedic Appliance (Prefabricated) that supports or eliminates motion of a weak or diseased body part. This does not include foot orthotics, functional or otherwise except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from Presbyterian Health Plan;
- Foot Orthotics or shoe appliances are **not c**overed, except for Members with diabetic neuropathy or other significant neuropathy. Custom-fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are covered for our Members in accordance with nationally recognized guidelines;
- Contact lenses for aphakia (those with no lens in the eye) or keratoconus;
- Sclera shells (white supporting tissue of eyeball);
- Initially, either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intra-ocular Surgery or ocular injury and prescribed by a Provider. (Duplicates are **not** covered, and replacement is covered only if a Provider or optometrist recommends a change in prescription due to the medical condition.);
- Hearing aids
    - School-aged children – hearing aids and the evaluation for fitting of hearing aids are covered for school aged children under 18 years old (or under 21 years of age if still

attending high school). The Plan pays 100% of the allowed amount every 36 months "per hearing impaired" ear

- Stethoscopes and manual blood pressure cuffs that are prescribed by a Provider. Automatic blood pressure cuffs or monitors are **not** covered unless the Member is physically unable to use a manual cuff; and
- Repairs or replacement of Durable Medical Equipment, prostheses and orthotics when Medically Necessary due to wear, change in the Member's condition or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan.



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

Surgically implantable devices and prostheses are covered as follows:

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

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

MEDICAL SUPPLIES

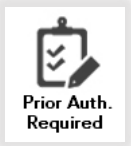
The following medical supplies are covered, not to exceed a one-month supply purchased during any 30-day period:

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

- Other supplies determined by Presbyterian Health Plan to be Medically Necessary and covered under the Plan.

Prior Authorization from Presbyterian Health Plan is required for:

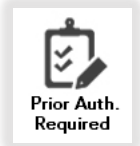
- Durable Medical Equipment, medical supplies (including enteral feeding tubes), Orthopedics Appliances, orthotics and surgically implanted Prosthetics; and
- Any item costing $500 or more in total charges dispensed in the Provider's office. (Total charges means either the total purchase price of the item or total rental charges for the estimated period of use. Rental charges considered for benefit payment will not exceed the purchase price of a new Unit.)



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

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

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



FAMILY PLANNING AND RELATED SERVICES

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

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

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

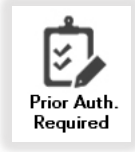
- Surgical treatments such as opening an obstructed fallopian tube, epididymis or vas when the obstruction is not the result of a surgical sterilization; and
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone being replaced.

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

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

GENETIC INBORN ERROS OF METABOLISM DISORDERS (IEM)

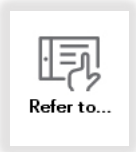
Coverage is provided for diagnosing, monitoring and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the Limitations and Exclusions and **Prior Authorization** requirements listed in this *SPD*. Medical services provided by licensed Healthcare Professionals, including Primary Care Providers, dieticians and nutritionists, with specific training in managing Members diagnosed with Genetic Inborn Errors of Metabolism (IEM) are covered.



Covered Services include:

- Nutritional and medical assessment;
- Clinical services;
- Biochemical analysis;
- Medical supplies;
- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM); and
- Nutritional management.

Please refer to your *Summary of Benefits* for applicable office visit, Inpatient Hospital, Outpatient facility and other related Copayments.



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

GYM MEMBERSHIP

Gym membership benefit. You and your enrolled Dependents (18 years and older) have access to a designated list of participating national, regional and local fitness, recreation and community centers as Presbyterian Health Plan Members.

Participating fitness facilities are subject to change. Presbyterian Health Plan is not responsible for ensuring certain facilities remain part of the participating network.

HABILITATIVE

AUTISM SPECTRUM DISORDER

The diagnosis and treatment for Autism Spectrum Disorder is covered in accordance with the state mandate 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.

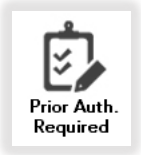
These services are only covered when a treatment plan is provided to Presbyterian Health Plan's Health Services Department prior to services being obtained. The Health Services Department will review the treatment plans in accordance with the state mandate.

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

HOME HEALTH CARE

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

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



The following home Health Care Services **are** covered:

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

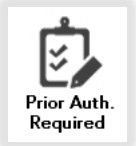
There are **no** home health care benefits provided for care that:

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

HOSPICE CARE

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

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



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

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

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

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

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

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

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

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

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

- Food, housing or delivered meals;
- Medical transportation;

- Comfort items;
- Homemaker and housekeeping services;
- Private duty nursing; and
- Pastoral and spiritual counseling.

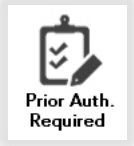
The following services are **not** benefits under Hospice but may be covered elsewhere under this booklet, subject to applicable Copayment and Coinsurance provisions:

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

HOSPITAL INPATIENT SERVICES

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

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



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

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

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

BLOOD

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

PHYSICAL REHABILITATION – INPATIENT

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

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

MASSAGE THERAPY

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

MATERNITY AND NEWBORN CARE

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

If Maternity benefits change during a pregnancy, the Member receives the benefits in effect on the day the service is received. Under Coverage that includes Dependents an unmarried Dependent daughter is eligible for Maternity benefits. Coverage for the newborn is available **only** if covered as an eligible Dependent.

Note:
Coverage for your newborn begins on your newborn's date of birth, provided that you are enrolled in County of Bernalillo Family Medical Coverage. (Please contact your employer's benefits office to finalize this enrollment. To avoid delay in claims payments, please finalize this enrollment within **31 days** from your newborn's date of birth). If you are not enrolled in County of Bernalillo Family Medical Coverage, your newborn **will not** be automatically covered from date of birth. In such case, you are required to enroll your newborn within **31 days** from your newborn's date of birth. In either case, you will be granted **61 days** from the

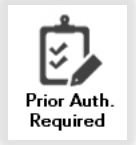
newborn's date of birth to provide your employer's benefits office with your newborn's birth certificate.

If the newborn is enrolled within **31 days**, the Plan pays benefits for your newborn's services, including newborn visits in the Hospital by the baby's Provider, circumcision, incubator and routine Hospital nursery charges. If your newborn needs special care including diagnostic tests and Surgery, the Plan pays benefits for that care too. A separate Inpatient Copayment, (or Deductible and/or Coinsurance for Out-of-network care) for your newborn applies only when the infant's Inpatient Stay exceeds the mother's date of discharge.

If your newborn stays in the Hospital longer than the mother does, you must notify the Presbyterian Health Plan Customer Service Center by calling **(505) 923-5678** or **1-800-356-2219 (TTY: 711)** before the mother is discharged from the Hospital, to coordinate the baby's care, or benefits may be reduced or denied.

NEWBORN AND MOTHERS HEALTH PROTECTION ACT

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



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

PROVIDER SERVICES

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

ALLERGY SERVICES

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

CHRONIC PAIN TREATMENT

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

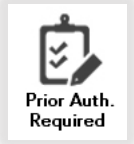
CONTRACEPTIVE DEVICES

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

- IUDs; and
- Diaphragms.

INJECTABLE DRUGS

FDA-approved therapeutic injections administered in a Provider's office are covered. However, certain injectable drugs (such as growth hormone and interferon alfa-2) are covered only when **Prior Authorization** is received from Presbyterian Health Plan. Your Presbyterian Health Plan contracted Provider has a list of those injectable drugs that require **Prior Authorization**. If you need a copy of the list, contact one of our Presbyterian Customer Service Center representatives, Monday through Friday, 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219. (TTY: 711)**. If you access care from an Out-of-network Provider or National Network Provider, you will have to obtain **Prior Authorization,** when required. Failure to do so may result in benefits being denied.



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

INPATIENT PROVIDER VISITS AND CONSULTATIONS

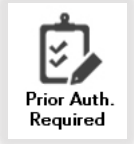
Attending Provider visits and consultations in the Hospital are benefits during a covered Admission.

OFFICE VISITS

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

WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING

Weight loss management, obesity treatment and nutritional counseling are **not** benefits unless dietary advice and exercise are provided by a Provider, licensed nutritionist, or registered dietician. Weight loss management, obesity treatment and nutritional counseling must be prescribed by a licensed Provider and are a benefit only when Medically Necessary and for a body mass index (BMI - weight in kilograms divided by height in meters squared) of 35 or more. Some Medical services associated with obesity treatment require **Prior Authorization**. If you access care through an In-



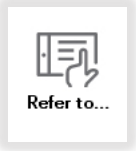
network Provider, they will obtain **Prior Authorization** when necessary. If you access care from an Out-of-network Provider or National Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Also, see Morbid Obesity.

PRESCRIPTION DRUG MEDICATIONS

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

Covered Prescription Drugs/Medications

Prescription Drug/Medication Benefit (Outpatient)

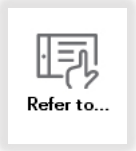


Outpatient Prescription Drugs are a Covered Benefit when prescribed by your Provider. Refer to your Formulary for information on the approved Prescription Drugs. For a complete list of these drugs, please see the PHP Commercial Large Group Plan formulary list at:

http://docs.phs.org/idc/groups/public/documents/communication/pel_00241799.pdf.

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 out In-network Providers, without cost sharing regardless of sex assigned at birth, gender identity, or gender of the individual.



Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Health Plan's Pharmacy website at:

http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00143765.pdf

You can call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-923-5678**. **(TTY: 711).**

The following drugs are covered when prescribed by your Provider and when purchased at an In-network Pharmacy. Refer to your *Formulary* for information on the approved Prescription Drugs/Medications.

- Medically Necessary prescription nutritional supplements for prenatal care for up to a 90-day supply up to the maximum dosing recommended by the manufacturer.
- Preferred insulin and diabetic oral agents for controlling blood sugar levels for up to a 90-day supply up to the maximum dosing recommended by the manufacturer.
- Immunosuppressant Drugs following Transplant Surgery for up to a 90-day supply up to the maximum dosing recommended by the manufacturer.

- Special Medical Foods used in treatment to compensate and maintain adequate nutritional status for Genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require **Prior Authorization.**
- Smoking Cessation Pharmacotherapy. Formulary drugs for up to a 90-day supply up to the maximum dosing recommended by the manufacturer. Smoking cessation is limited to two 90-day courses of treatment per Plan Year.

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 Provider, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

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

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

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

CAN THE FORMULARY CHANGE DURING THE YEAR?

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

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

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

HOW IS THE FORMULARY DRUG LIST DEVELOPED?

The medications and related products listed on a formulary are determined by a Pharmacy and Therapeutics (P&T) Committee or an equivalent entity. The Presbyterian Health Plan P&T

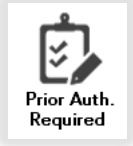
Committee is made up of Primary Care and specialty Providers, clinical pharmacists and other professionals in the healthcare field.

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

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

WHAT IS A PRIOR AUTHORIZATION?

Prior Authorization is a clinical evaluation process to determine if the requested 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 and, if it meets our requirements for Coverage and Medical Necessity, it is Authorized (approved) before those services are provided.



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

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

WHAT IS STEP THERAPY?

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

WHAT ARE QUANTITY LIMITS?

Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your Provider and pharmacist check that the medications are used appropriately and promote patient

safety. Presbyterian Health Plan uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following:

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

DRUG UTILIZATION REVIEW AND DRUG USE EVALUATION PROGRAMS

Drug Utilization Review (DUR) is a review of patient data which is done to evaluate the effectiveness, safety and appropriateness of medication use. These DURs occur during claim adjudication and 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 DURs 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 Presbyterian Health Plan Commercial Large Group Plan Formulary covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand name drug. Generally, generic drugs cost less than brand name drugs.

BRAND NAME DRUGS WHEN A GENERIC EQUIVALENT IS AVAILABLE

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

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

BENEFIT LIMITATIONS

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

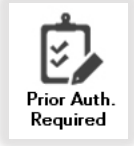
You have the option to purchase up to a 90-day supply of Prescription Drugs/medications. Under the up to a 90-day at Retail Pharmacy benefit, Preferred Generic, Preferred Brand and Non-Preferred Drugs can be obtained from an In-network Pharmacy. If you choose the 90-days at retail option, you will be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

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

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

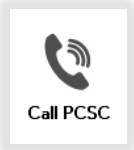
SELF-ADMINISTERED SPECIALTY PHARMACEUTICALS

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



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

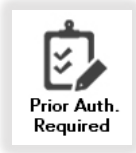
For a complete list of these drugs, please see the Specialty Pharmaceutical listing at **http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf.**

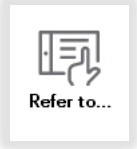


You can call our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219. (TTY: 711)**.

OFFICE ADMINISTERED SPECIALTY PHARMACEUTICALS (MEDICAL DRUG)

A Medical Drug is any drug administered by a healthcare Provider and is typically given in the Member's home, the Provider's office, a freestanding (ambulatory) infusion suite or an Outpatient facility. Medical drugs 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.*



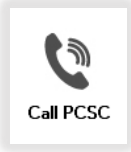


For a complete list of Medical Drugs to determine which require **Prior Authorization** please see the Presbyterian Health Plan Pharmacy website:

http://docs.phs.org/idc/groups/public/%40phs/%40php/documents/phscontent/pel_00052739.pdf

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. You may obtain more information on the Mail Service Pharmacy by calling our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5678** or **1-800-356-2219 (TTY: 711)**.



- Cost-Sharing Copayments at the applicable Tier Copayment.
- Certain drugs may not be purchased by mail order, such as Self-Administered Specialty Pharmaceuticals.

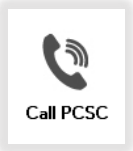
MEMBER REIMBURSEMENT

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

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

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

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) 923-5678** or **1-800-356-2219 (TTY:711)**. Please follow the mailing instructions on the Member Reimbursement Form.



A Pharmacy Services Call Center is available 24 hours a day to Providers, Pharmacies and Members to address Pharmacy benefit questions. Members can contact PCSC at **1-800-923-5678**. A registered professional nurse or Provider shall be immediately available by telephone seven days a week, 24 hours a day, to render utilization management determinations for Providers.

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

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

PREVENTIVE SERVICES

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

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

PREVENTIVE SERVICES FOR WOMEN

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

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

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

CYTOLOGIC SCREENING (PAP SMEAR SCREENING)

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

EVIDENCE-BASED ITEMS OR SERVICES

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

Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

HUMAN PAPILLOMAVIRUS (HPV) SCREENING

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

HEALTH EDUCATION AND COUNSELING

Health education and counseling services will be provided if recommended by your treating Provider and if consistent with the Presbyterian Health Plan policy, including:

- If you are 20 years of age or older, you may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. Included in the consultation may be, but not limited to:
    - Smoking control
    - Nutrition and diet recommendations
    - Exercise plans
    - Lower back protection
    - Immunization practices
    - Breast self-examination
    - Testicular self-examination
    - Use of seat-belts in motor vehicles
    - Other preventive healthcare practices
- If you are under age 20, educational materials or consultation to discuss lifestyle behaviors that promote health and well-being including, but not limited to:
    - The consequences of tobacco use
    - Nutrition and diet recommendations
    - Exercise plans
    - As deemed appropriate by the Attending Provider or as requested by the parents or legal guardian for children under 18, educational information on alcohol and substance use, sexually transmitted infections and contraception.

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

MAMMOGRAPHY COVERAGE

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

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

PROSTATE EXAMS

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

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

ROUTINE VISION SCREENING

Routine vision screenings provided by licensed Providers to determine the need for vision correction are a Covered Service and are limited to screening only for Members through age 17. This does not include routine eye exams or refractions performed by eye care Providers.

ROUTINE HEARING SCREENING

Routine hearing screenings performed only by licensed Providers to determine the need for hearing correction are a benefit and are limited to screening only for Members through age 17.

ROUTINE IMMUNIZATIONS

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

ROUTINE PHYSICAL EXAMINATIONS

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

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

- Periodic blood cholesterol, or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level;
- Periodic stool examination for the presence of blood for Members age 40 or older;
- Periodic left-sided colon examination of 35 to 60 centimeters for Members age 45 or older; and
- Periodic glaucoma eye tests for Members age 35 or older.

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

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

WELL-CHILD CARE

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

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

SKILLED NURSING FACILITY

A Skilled Nursing Facility provides room and board and Skilled Nursing services for Medical Care and has one or more licensed nurses on duty at all times supervised on a 24-hour basis by a Registered Nurse (RN) or a healthcare Provider, and the services of the Provider are available at all times by an established agreement. The facility must also comply with the legal requirements that apply to its operation and keep daily medical records on all patients.

A Skilled Nursing Facility is not an institution, or part of one, used mainly for rest care, care of the aged, care of substance use disorder treatment, Custodial Care or educational care.

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

SMOKING CESSATION

Benefits are available for smoking cessation expenses up to a Maximum benefit per Member per lifetime as shown in the *Summary of Benefits*. This benefit includes Acupuncture, hypnotherapy and other recognized smoking cessation programs that are covered through the medical portion of the Plan.

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.

In addition, benefits include Nicorette or any other drug containing nicotine or other smoking deterrent medications.

SURGERY

Benefits are available for the following surgical services:

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

Cosmetic or plastic Surgery or reconstruction procedures, such as breast augmentation, rhinoplasty, surgical alteration of the eye and surgical correction of prognathism, that

Presbyterian Health Plan determines are not required to materially improve the physiological function of an organ or body part are **not** Covered Services. Services for the reconstruction of surgically induced scars are not benefits under any circumstances. Also, most Surgeries require a **Prior Authorization.** In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or National Network Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Provider.

CARDIAC SURGERY

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

CATARACT SURGERY

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

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

COCHLEAR IMPLANTS

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

CONGENITAL ANOMALIES

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

MORBID OBESITY

Benefits are available for surgical treatment of morbid obesity (bariatric Surgery) **only** when prescribed by a licensed Provider, when Medically Necessary, and with a body mass index (BMI - weight in kilograms divided by height in meters squared) of 35 or more.

Prior Authorization may be required from Presbyterian Health Plan prior to services being rendered. If you access care through an In-network Provider, they will obtain **Prior Authorization,** when necessary. If you access care from an Out-of-network Provider or National Network Provider, you will have to **obtain Prior Authorization.** Failure to do so may result in benefits being reduced or denied. Also, see Weight Management.

ORAL SURGERY

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

OUTPATIENT SURGERY

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

RECONSTRUCTIVE SURGERY

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

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

MASTECTOMY SERVICES

Medically Necessary hospitalization related to a covered mastectomy, including at least 48 hours of Inpatient care following a mastectomy and 24 hours following a lymph node dissection is covered.

When breast reconstruction is chosen, Covered Services include:

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

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

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

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

THERAPY

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

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

These services may also include treatment using cold, heat or similar modalities to relieve pain, restore maximum function and prevent disability following illness, Accidental Injury or loss of a body part.

Benefits are **not** available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.

RESTORATIVE SPEECH THERAPY

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

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

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

TRANSPLANT SERVICES

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

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
- 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
    - Wilm's 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 in-state, 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 l**imited** to a lifetime maximum of $10,000. All organ transplants must be performed at a site that we approve and will require **Prior Authorization**.

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

LIMITATIONS AND EXCLUSIONS

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

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

LIMITATIONS

The following benefits have limits applied:

Acupuncture treatment benefits are limited to a Plan Year Maximum of 18 visits per Plan Year per Member for covered expenses, in combination with services provided for chiropractic.

Air ambulance charges for non-emergencies will be covered only if Medically Necessary.

Autism Spectrum Disorder- service received under the federal individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services.

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

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

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

Biofeedback treatment is limited to services for Raynaud's disease/phenomenon, urinary incontinence, chronic pain, tension headaches, migraines, craniomandibular joint (CMJ) disorders and temporomandibular joint (TMJ) disorders. Biofeedback is a benefit only when provided by a Primary Care Provider, a Doctor of Osteopathy, a professional psychologist, or a board certified biofeedback therapist.

Chiropractic (manipulations) services are limited to a Plan Year maximum benefit of 20 visits per Plan Year per Member for covered expenses, in combination with services provided for Acupuncture.

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

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

Dental Services
This Plan covers only those procedures listed as Covered Benefits. This Plan does not cover any other oral or dental procedures such as, but not limited to:

- Inpatient services that are provided when **Prior Authorization** is not obtained from Presbyterian Health Plan (except initial treatment of accidental injuries);
- Nonstandard services (diagnostic, therapeutic, or surgical);
- Dental treatment or Surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an Accidental Injury;
- Removal of impacted teeth; dental services needed due to a medical condition or a medical or surgical procedure (e.g., chemotherapy or radiation therapy); removal of tori or exostosis; procedures involving orthodontic care, the teeth, dental implants, periodontal disease; or preparing the mouth for dentures;
- Duplicate or "spare" appliances;
- Artificial devices and/or bone grafts for denture wear; and
- Personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth.

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

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

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

Durable Medical Equipment, Orthotic and Prosthetic Devices and external prostheses require **Prior Authorization** when costs exceed $1,000. If you obtain services from an In-network Provider, they will request **Prior Authorization** from PHP. If you obtain services from a National Network Provider, then it is your responsibility to obtain **Prior Authorization**. Failure to do so will result in benefits being denied.

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

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

- School aged children's hearing aids and the evaluation for fitting of hearing aids are covered for school aged children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount every 36 months "per hearing impaired" ear.

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

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

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

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

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

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

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

Physical, occupational and speech therapy are limited to 24 visits per Member per condition per Plan Year per therapy. These services also require **Prior Authorization**.

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

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

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

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

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

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

Respite care (care that provides a relief for the caregiver) for a period not to exceed five continuous days for every 60 days of Hospice care. No more than two respite care stays will be available during a Hospice benefit period.

Routine eye screenings are limited to Dependents through age 17.

Routine hearing screenings are limited to Dependents through age 17.

Skilled Nursing Care is subject to **Prior Authorization**. If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan. If you obtain services from an out-of-network National Network Provider, then it is your responsibility to obtain **Prior Authorization**. Failure to do so will result in benefits being denied.

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

Substance Use Disorder benefits are limited as follows: All Inpatient services require **Prior Authorization** to be considered an eligible expense under this Plan.

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

Transplants - Benefits for travel, lodging and meals are limited to an adult transplant recipient and one other person. For minor children, benefits are payable for two adults. Lodging and meals are limited to $150 per day per person, including the transplant patient, to a maximum lifetime benefit payment of $10,000, to include transportation. Donor organ procurement costs for the surgical removal, storage and transportation of the donated organ are covered for Medicare Allowable Amounts.

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

EXCLUSIONS

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

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

Admissions/treatments discontinued by patient including charges associated with any episode of Alcohol or Substance Use Disorder for which the patient did not complete the prescribed continuum of care may not be covered under this Plan.

Adoption/surrogate expenses are **not** a Covered Benefit.

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

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

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

Autopsies are **not** a Covered Benefit under this Plan.

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

Behavioral disorders are **not** a Covered Benefit under this Plan unless associated with a manifest mental disorder.

Behavioral health and Alcohol and/or Substance Use Disorder for the following are **not** Covered:

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

Behavioral training is **not** a Covered Benefit under this plan.

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

Charges

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

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

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

Contact lenses or eyeglasses unless specifically listed as a Covered Benefit under this Plan.

Convalescent care or rest cures.

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

Counseling services are **not** a Covered Benefit under this Plan unless listed as a Covered Service.

Court ordered services are **not** a Covered Benefit under this Plan.

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

Custom-Fabricated knee-ankle-foot orthoses (AFO and/or KAFO) except for Members with diabetic neuropathy or other significant neuropathy when **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided.

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

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

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

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

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

Donor expenses incurred by a Member are **not** a Covered Benefit under this Plan, except as specified in this *Summary Plan Description*.

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

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

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

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

Environmental control expenses are **not** Covered Benefits under this Plan.

Exercise equipment is **not** a Covered Benefit under this Plan. Experimental or Investigational services/treatment are **not** Covered Benefits.

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

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

Eye exercises and refractions are **not** a Covered Benefit under this Plan.

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

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

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

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

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

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

Hearing aids
School aged children – hearing aids and the evaluation for fitting of hearing aids are covered for school aged children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount every 36 months "per hearing impaired" ear. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit.

Home births

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

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

Additionally, the following services are not benefits under Hospice but may be covered elsewhere under this booklet:

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

Human Chorionic Gonadotrophin (HCG) injections are not a Covered Benefit under this Plan.

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

Implantation of artificial organs or mechanical devices, except as specified in this booklet, is not a Covered Benefit under this Plan unless as a result of illness or injury and **Prior Authorization** is obtained from Presbyterian Health Plan prior to services being provided. If you obtain services from an In-network Provider, they will request **Prior Authorizations** from Presbyterian Health Plan, when required. If you obtain services from a National Network Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior Authorization** when required, benefits will be administered at the Out-of-network level.

Infertility services, listed below, are not Covered.

- 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.

Intradiscal Electrothermal Therapy (IDET) is not a Covered Benefit under this Plan.

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

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

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

specified by the Health and Human Services Department when benefits are payable under Medicare.

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

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

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

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

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

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

Membership fees are not included in the exclusion.

Meniscal Transplants are not a covered benefit under this Plan.

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

Non-covered Providers: Members of your immediate family or one normally residing in your home, health spas or health fitness centers, private sanitariums, nursing homes, rest homes, or dental or medical departments sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

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

Non-medical equipment is **not** a Covered Benefit under this Plan.

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

Nonprescription and over the counter drugs as well as:

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

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

Nonstandard or deluxe equipment is not a Covered Benefit under this Plan.

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

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

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

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

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

Orthoptics are not a Covered Benefit under this Plan.

Orthotripsy is not a Covered Benefit under this Plan.

Over the counter contraceptive medications and supplies are not a Covered Benefit under this Plan.

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

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

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

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

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

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

Private room expenses are not a Covered Benefit under this Plan unless there is documented Medical Necessity.

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

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

Repair or replacement of Durable Medical Equipment, orthotic appliances and Prosthetic Devices due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience.

Reversals of surgical procedures are not a Covered Benefit under this Plan.

Self-help programs and therapies not specifically covered in this booklet, such as behavior modification; music, art, dance, recreation and Z therapy; massage therapy except when

performed by a Licensed Physical Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine or Chiropractor.

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

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

Speech therapy charges not otherwise listed as a Covered Benefit under this Plan.

Sperm storage is not a Covered Benefit under this Plan.

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

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

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

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

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

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

Unreasonable charges will not be covered by this Plan.

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

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

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

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

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

Vocational rehabilitation services are **not** a Covered Benefit under this Plan.

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

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

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

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

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

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

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

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

FILING CLAIMS

This is a PPO-type Plan wherein the In-network Providers have agreed to file your claims directly to Presbyterian Health Plan (PHP) and payment is made directly to the Provider. Presbyterian Health Plan has arranged to provide additional coverage with National Network Providers when you obtain Covered Services outside of New Mexico. If you obtain Covered Services outside of New Mexico from National Network Providers, they will file the claim with PHP for you.

On occasion you may access care from an Out-of-network Provider, such as in an emergency when you are traveling out of the Service Area. In such cases you may have to file a claim yourself.

EMERGENCY SERVICES OR OUT-OF-NETWORK PROVIDERS

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

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

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

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

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

OUT-OF-NETWORK SERVICE CLAIMS

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

CLAIMS OUTSIDE THE UNITED STATES

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

ITEMIZED BILLS

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

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

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

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

HOW PAYMENTS ARE MADE

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

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

If you obtain services from an Out-of-network Provider, you are responsible for any amounts greater than Medicare Allowable Amounts. You are also responsible for paying all Copayments, Deductibles, Coinsurance and non-Covered Services.

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

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

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

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

OVERPAYMENTS

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

COORDINATION OF BENEFITS

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

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

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

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

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

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

b. Medicare;
c. benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired employee.

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

3. **Dependent child/parents not separated or divorced**. If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Plan Year pays first. If the other valid coverage does not follow the birthday rule, then the gender rule applies (that is, the male parent's coverage pays first).

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

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

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

If a Member receives more than they should have when benefits are coordinated, the Member is required to repay any overpayment.

Your other valid coverage may be with a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or another program that limits or excludes benefits if you do not

meet the obligations for obtaining **Prior Authorization** of care, for obtaining the proper level of care for the condition treated or for obtaining services from Providers authorized or recognized by your primary carrier. If you do not meet these obligations and your primary benefits are reduced as a result, Presbyterian Health Plan limits its secondary benefit payment to the difference between the Presbyterian Health Plan Negotiated Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations recognized by your primary carrier.

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

EFFECT OF MEDICARE ON BENEFITS

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

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

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

If Medicare coverage coexists with this Plan, Medicare will be secondary until the Plan pays primary for at least 30 months from the date the Member became eligible for or entitled to Medicare on the basis of end-stage renal disease.

EFFECT OF MEDICAID ON BENEFITS

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

SUBROGATION

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

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

ASSIGNMENT OF BENEFITS

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

FRAUDULENT APPLICATION OR CLAIM

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

GRIEVANCE PROCEDURES

OVERVIEW

Many Grievances or problems can be handled informally by calling Presbyterian Health Plan at **(505) 923-5678 or at 1-800-356-2219**.

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

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

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

Any Grievance may be submitted orally or in writing. If you make an oral Grievance, our Presbyterian Customer Service Center (PCSC) will assist you to complete the required forms. Please be advised that PHP shall not take any retaliatory action against you for filing a Complaint.

You may request a copy and detailed written explanation of the Grievance procedures by calling the Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**.

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

ADVERSE DETERMINATION REVIEW PROCEDURES

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

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

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

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

ADMINISTRATIVE GRIEVANCE PROCEDURES

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

COUNTY OF BERNALILLO GRIEVANCE REVIEW PROCEDURES

If the grievant is not satisfied with Presbyterian Health Plan's decision under either category above, he/she may appeal the decision by filing a formal complaint to the Authority within 30 days of the day the Grievance decision was made. (**Note:** You may contact the County of Bernalillo at any time during the Grievance process.) Upon receipt of the appeal request, the Authority will review the case and respond to the parties involved within 30 days. If the appeal is due to an emergency situation, a response will be given within 48 hours of receipt of such formal appeal request.

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

EXTERNAL REVIEW BY SUPERINTENDENT OF INSURANCE

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

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

RETALIATORY ACTION

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

MEMBER RIGHTS AND RESPONSIBILITES

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health Plan. Above all, your relationship with your Provider is essential to good health. We encourage open communication between you and your Provider.

MEMBER RIGHTS:

A. All Members have a right to:

1. Be treated with courtesy, consideration, respect and recognition of their dignity.

2. Have their privacy respected, including the privacy of medical and financial records maintained by the Claim Administrator and its healthcare Providers as required by law.

3. Request and obtain information concerning the Claim Administrator's policies and procedures regarding products, services, In-network Providers, Appeals procedures and other information about the Claim Administrator and the benefits provided.

4. Request and obtain information about any financial arrangements between the Claim Administrator and its In-network Providers, which might restrict treatment options or limit services offered to Members.

5. Be told the details about what is covered, maximum benefits, what is **not covered**, what drugs or medicines are covered, and how to obtain **Prior Authorizations**, when needed.

6. Receive affordable healthcare, with limits on Out-of-pocket expenses.

7. Seek care from an Out-of-network Provider and be advised of their financial responsibility if they receive services from an Out-of-network Provider or receive services without required **Prior Authorization**.

8. Be notified promptly of termination, decreases or changes in benefits, services or the Provider network.

9. Participate with treating Providers in making decisions about their healthcare.

10. Clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost.

11. Refuse care, treatment or medications after the Provider has explained the care, treatment or other advice and possible consequences of this decision in language that the Member understands.

12. Have adequate access to qualified health professionals near where they live or work.

13. Receive information from their Provider, in terms that they understand, including an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives irrespective of the Claim Administrator's position on treatment options.

14. Have the explanation provided to next of kin, guardian, agent or surrogate if available, when the Member is unable to understand.

15. Have all explanations to the next of kin, guardian, agent or surrogate recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member.

16. Have access to services, when Medically Necessary, as determined by their primary or treating Provider, in consultation with the Claim Administrator, 24 hours per day, seven days a week for Urgent or Emergency Health services, and for other health services as defined by this booklet.

17. Have access to translator services for Members who do not speak English as their first language, and translation services for hearing-impaired Members for communication with the Claim Administrator.

18. Receive a complete explanation of why services or benefits are denied, an opportunity to Appeal the decision to the Claim Administrator, the right to a secondary Appeal and the right to request the Superintendent of Insurance assistance and to receive an answer within a reasonable time.

19. Make complaints or Appeals regarding the Claim Administrator or the care provided.

20. Continue an ongoing course of treatment for a period of at least 30 days if the Member's Provider leaves the Provider network or if a new Member's Provider is not in the Provider network.

21. Make recommendations regarding the Claim Administrator's Members' Rights and Responsibilities policy.

MEMBER RESPONSIBILITIES:

B. All Members must:

1. Review this booklet and if there are questions contact the Presbyterian Customer Service Center at **(505) 923-5678** or toll-free at **1-800-356-2219** (ASK PRES) for clarification of benefits, limitations and exclusions outlined in this booklet.

2. Provide, as much as possible, information that the Claim Administrator and Providers need in order to provide services or care or to oversee the quality of such care or services.

3. Follow the Claim Administrator's policies, procedures and instructions for obtaining services and care.

4. Follow the plans and instructions for care that he/she has agreed upon with his/her Provider. A Member may, for personal reasons, refuse to accept treatment recommended by In-network Providers. An In-network Provider may regard such refusal as incompatible with the continuance of the Provider-patient relationship and as obstructing the provision of proper Medical Care.

5. Notify the Claim Administrator immediately of any loss or theft of his/her Identification Card.

6. Refuse to allow any other person to use his/her Identification Card.

7. Advise an In-network Provider of coverage with the Claim Administrator at the time of service. Members may be required to pay for services if they do not inform their In-network Provider of their coverage.

8. Pay all required Copayments, Deductibles and/or Coinsurance at the time services are rendered.

9. Be responsible for the payment of all services obtained prior to the effective date of this Plan and subsequent to its termination or cancellation.

10. Promise that all information given to the Claim Administrator in Applications for enrollment, questionnaires, forms or correspondence is true and complete.

11. Understand their health problems and participate in developing mutual agreed upon treatment goals to the highest degree possible.

GLOSSARY OF TERMS

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

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

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

ALCOHOL USE DISORDER means alcohol dependence or alcohol use meeting the criteria as stated in the *Diagnostic and Statistical Manual V* for these disorders.

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

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

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

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

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

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 V*, published by the American Psychiatric Association, including Autistic

Disorder; Asperger's Disorder; Pervasive Development Disorder not otherwise specific; Rett's Disorder; and Childhood Disintegrative Disorder.

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

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

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

CODEPENDENCY means behaviors learned by family members or significant others in order to survive in an environment of great emotional pain and stress when a family member is dependent upon the use of alcohol or drugs.

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

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

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

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

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

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

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

components. It involves more than trimming, bending or making other modifications to a substantially Prefabricated item.

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

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

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

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

DIAGNOSTIC SERVICES means procedures ordered by a Provider or other Healthcare Provider to determine a definite condition or disease.

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

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

EXPERIMENTAL/INVESTIGATIONAL means any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical practice in the state in which services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered,

the service is Experimental. To be considered standard medical practice and **not** Experimental or Investigational, treatment must meet all five of the following criteria:

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

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

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

FREESTANDING HEALTHCARE FACILITIES are those that are stand alone and on their own and deliver many diagnostic and therapeutic services formerly provided only in Hospitals.

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

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

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

- Availability, delivery or quality of Health Care Services;
- Administrative practices of the healthcare insurer that affect the availability, delivery or quality of Health Care Services;
- Claims payment, handling or reimbursement for Health Care Services; or
- Matters pertaining to any aspect of the health benefits Plan.

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

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

HOME HEALTH AGENCY means an appropriately licensed Provider that both:

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

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

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

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

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

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

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

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

INPATIENT means a Member who has been admitted by a healthcare Provider to a Hospital for occupancy for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for

which there is a room and board charge, and which are covered as defined in this Plan. Admissions are considered Inpatient based on Medical Necessity as identified in the Presbyterian Health Plan designated level of care criteria, regardless of the length of time spent in the Hospital.

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

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

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

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

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

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

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

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

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

- It is medical in nature; and
- It is recommended by the treating Provider; and
- It is the most appropriate supply or level of service, taking into consideration:
- Potential benefits;
- Potential harms;
- Cost, when choosing between alternatives that are equally effective;
- Cost-effectiveness, when compared to the alternative services or supplies;
- It is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established

services or supplies, professional standards and expert opinion may also be taken into account); and
- It is not for the convenience of the Member, the treating Provider, the Hospital, or any other healthcare Provider.

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

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

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

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

MEMBER BENEFIT BOOKLET means this booklet.

OBSERVATION means those furnished by a Hospital and 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 as an Inpatient, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under Outpatient Observation stay, it is on the Provider's written order. If not formally admitted as an Inpatient, the patient initially is treated as an Outpatient. The Member must meet the Presbyterian Health Plan designed level of care criteria to be considered an Inpatient Admission. The length of time spent in the Hospital is not the sole factor for determining Observation versus Inpatient status.

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

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

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

  - Ambulance Provider
  - Ambulatory Surgical Facility
  - Birthing Center
  - Durable Medical Equipment Supplier
  - Freestanding Dialysis Facility
  - Home Health Agency
  - Hospice Agency
  - Independent Clinical Laboratory
  - Pharmacy
  - Rehabilitation Hospital
  - Urgent Care Facility
- A person or Provider only listed as:
  - Certified Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - Chiropractor
  - Dentist
  - Licensed Acupuncturist
  - Licensed Practical Nurse
  - Occupational Therapist
  - Physical Therapist
  - Podiatrist
  - Licensed Lay Midwife
  - Registered Nurse
  - Respiratory Therapist
  - Speech Therapist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REGISTERED NURSE (RN) means a nurse who has graduated from a formal program of nursing education diploma school, associated degree or baccalaureate program and is licensed by appropriate state authority.

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

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

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

SERVICE AREA means the entire state of New Mexico.

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

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

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

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

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

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

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

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

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

TEFRA means Federal law regarding the working aged.

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

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

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

ACCEPTANCE PAGE

ACCEPTANCE PAGE

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

[By: _____] [Date: _____]