PRESBYTERIAN

New Mexico Public Schools Insurance Authority (NMPSIA)

PPO Medical Plan
Summary Plan Description

Offered by New Mexico Public Schools Insurance Authority (NMPSIA)
Administered by Presbyterian Health Plan

NMPSIA PPO SPD
MPC072206 [1/1/2022]

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

Address:
Presbyterian Insurance Company, Inc.
Attention: Presbyterian Customer Service Center
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone:
(505) 923-5600 or
1-888-275-7737
TTY 711

Prior Authorization

Address:
Presbyterian Insurance Company, Inc.
Attention: Health Services Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:
(505) 923-5600 or
1-888-275-7737

Claims

Address:
Presbyterian Insurance Company, Inc.
Attention: Claims Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:
(505) 923-5600 or
1-888-275-7737

Appeals and Grievances

Address:
Presbyterian Insurance Company, Inc.
Attention: Grievance Department
P.O. Box 26267
Albuquerque, NM 87125-6267

Phone:
(505) 923-5600 or
1-888-275-7737
Fax:
(505) 923-6111

OR

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

Phone:
1-855-427-5674
Fax:
(505) 827-4734

Website

www.phs.org

Welcome

This benefit booklet describes the medical benefits offered through the New Mexico Public Schools Insurance Authority (NMPSIA).

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

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

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

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

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

Introduction

The New Mexico Public Schools Insurance Authority provides group healthcare coverage through the Preferred Provider Organization (PPO) Medical Plan (Plan) administered by Presbyterian Health Plan, Inc.

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

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

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

This PPO Plan allows you to choose, at the time you receive services, the level of benefits that will apply. **You receive the highest benefit level with the lowest cost to you when you obtain services from a Preferred Provider.** *The Presbyterian Health Plan Provider Directory* lists the Preferred Providers. The Provider Directory is available through the Presbyterian website at www.phs.org, or you can obtain one by contacting the Presbyterian Customer Service Center at (505) 923-5600 or toll free at 1-888-275-7737. **(TTY: 711).**

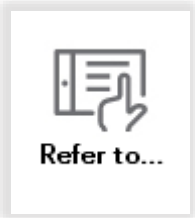
Additionally, Presbyterian Health Plan now contracts with MultiPlan, a National Preferred Provider organization with over 3,500 acute care Hospitals and 400,000 practitioners. If you live or are traveling outside the State of New Mexico, and require medical attention, we encourage you to see MultiPlan practitioners and facilities. MultiPlan Providers provide care to Presbyterian Health Plan Members at discounted rates, which help keep the cost of medical care down. Additionally, you cannot be charged for any difference between what Presbyterian Health Plan pays the Provider and what the Provider charges beyond your appropriate Copay and/or Deductible and Coinsurance (see Section 1 - How the Plan Works). The MultiPlan Provider Directory is available through their website at www.multiplan.com or you can contact the Presbyterian Customer Service Center, Monday through Friday from 7:00 a.m. and 6:00 p.m. at (505) 923-5600 (in Albuquerque), or **toll free** within New Mexico at 1-888-275-7737(Ask-PRES).

Please take the time to read this booklet carefully before placing it in a safe place for future reference. If you have any questions regarding this booklet, please call the Presbyterian Customer Service Center, Monday through Friday from 7:00 a.m. and 6:00 p.m. at (505) 923-5600 or **toll free** within New Mexico at 1-888-275-7737 (Ask-PRES). It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under this Plan.

Table of Contents

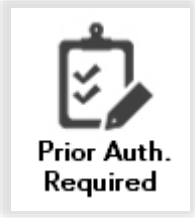
Understanding This Summary Plan Description

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 Agreement or *Summary of Benefits and Coverage* when necessary. The Section being referenced will be bolded.

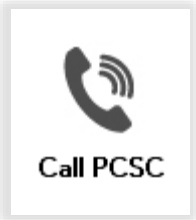
Exclusion – This "Exclusion" symbol will appear next to the description of certain Covered Benefits. The Exclusion symbol will alert you that there are some services that are excluded from the Covered Benefits and will **not** be paid. You should refer to the Exclusion Section when you see this symbol.



Prior Authorization Required – This "**Prior Authorization**" symbol will appear next to those Covered Benefits that require our Authorization (approval) in advance of those services. To receive full benefits, your In-network Practitioner/Provider must call us and obtain Authorization before you receive treatment. You must call us if you are seeking services Out-of-network. In the case of a Hospital in-patient admission following an Emergency Room visit, you or your physician should call as soon as possible.

Timeframe Requirement – This "Timeframe" symbol appears to remind you when you must take action within a certain time frame 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 you 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 Agreement and the *Summary of Benefits and Coverage* will be capitalized. These terms are defined in the Glossary of Terms Section.

Customer Assistance

Presbyterian Customer Service Center (PCSC)

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

Our Presbyterian Customer Service Center representatives are available Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5600** or **1-888-275-7737**. Hearing impaired users may call **TTY 711**. You may visit our website for useful health information and services at www.phs.org.

Consumer Assistance Coordinator

If you need assistance completing any of our forms, if you have special needs, or if you need assistance in protecting your rights as a Member, please call our Consumer Assistance Coordinator at **(505) 923-5600** or **1-888-275-7737**. Hearing impaired users may call **TTY 711** or visit our website at www.phs.org.

Written **Correspondence**

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

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

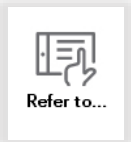
How the Plan Works

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

In-Network Providers

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

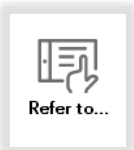
Out-of-Network Benefits



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

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

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

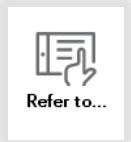


Please refer to your *Summary of Benefits and Coverage*, the Benefit Section and the Exclusions Section for a complete listing of Covered and Excluded services.

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

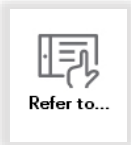
If you are referred to an Out-of-network Practitioner/Provider, services from that Out-of-network Practitioner/Provider are subject to the Out-of-network benefit levels shown in the Summary of Benefits and Coverage.

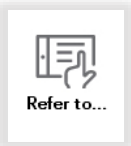
Out-of-Network Providers



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

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

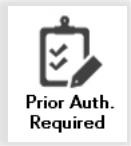




Some services are **not** covered when received from Out-of-network Providers. Please refer to your *Summary of Benefits and Coverage* and throughout this document for a complete listing of Covered Services.

WHAT IS PRIOR AUTHORIZATION?

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



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

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

WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION?

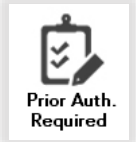
Certain procedures or services, as identified in the next subsection of this document, do require **Prior Authorization**. The responsibility for obtaining **Prior Authorization** is as follows:

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

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

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 recommends you be admitted as an Inpatient to a Hospital or treatment facility, you are responsible for any **Prior Authorization** requirement for Inpatient Admissions. If **Prior Authorization** is **not** obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits and Coverage*.



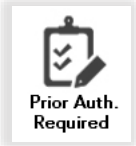
If Presbyterian Health Plan determines that the Admission was for a covered service but hospitalization was **not** Medically Necessary, **no** benefits are paid for Inpatient room and board charges and these expenses do **not** apply toward the Out-of-pocket Maximum. Other Covered Services are paid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

All Admissions for Behavior Health and Alcoholism 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 New Mexico Public Schools Authority. Contact our Presbyterian Customer Service Center, Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5600** or **1-888-275-7737** (**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 for an Out-of-network Provider or MultiPlan Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services:

- Acute Medical Detoxification
- All Hospital admissions, Inpatient non-emergent
- Applied Behavior Analysis
- Bariatric Surgery and Surgery for the treatment of obesity
- Cancer Clinical Trials
- Clinical Trials (Investigational/Experimental)
- Certified Hospice Care
- Computed Axial Tomography (CAT) scans in an outpatient setting
- Detoxification (acute requiring medical intervention)
- Durable Medical Equipment
- Electroconvulsive Therapy (ECT)
- Epidural Injections for Back Pain
- Foot Orthotics
- Gender Confirmation Surgery
- Genetic/Genomic Testing
- Home Health Care Services/Home Health Intravenous Drugs
- Hospice
- Hospital Admissions
- Hyperbaric Oxygen
- Injectable drugs (includes Specialty Medications and Medical Drugs_
- Injectable over $100 and certain injectable received in the Provider's office
- Magnetic Resonance Imaging (MRI) in an outpatient setting
- Medical Supplies greater than $1,000
- Mental Health services - Inpatient, Partial Hospitalization and select outpatient services
- Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems
- Morbid Obesity Treatment
- Newborn Delivery and Hospital Obstetrical services

- Non-emergency care when traveling outside the U.S.
- Nutritional Supplements
- Observation Services greater than **24 hours**
- Organ transplants/Transplant Services
- Orthotics
- Positron Emission Tomography (PET) scans in an outpatient setting
- Prosthetic Devices (listed under Durable Medical Equipment, Appliances, Hearing Aids, Medical Supplies, Orthotics, and Prosthetics Subsection)
- Prosthetic Devices
- Proton Beam Irradiation
- Reconstructive Surgery and potentially cosmetic procedures
- Repair or replacement of non-rental DME
- Selected Surgical/Diagnostic procedures
    - Blepharoplasty (surgery on the upper eyelid)/Brow Ptosis Surgery
    - Breast Reconstruction following Mastectomy
    - Breast reduction for gynecomastia
    - Cholecystectomy by Laparoscopy
    - Endoscopy Nasal/Sinus balloon dilation
    - Hysterectomy
    - Lumbar/Cervical Spine Surgery
    - Meniscus Implant and Allograft/Meniscus Transplant
    - Morbid Obesity Surgery
    - Panniculectomy
    - Rhinoplasty
    - Tonsillectomy
    - Total Ankle Replacement
    - Total Hip Replacement
    - Total Knee Replacement
    - Vein Surgery
- Skilled Nursing Facility care
- Some Prescription Drugs/Medications
- Special Inpatient services (including but not limited to private room and board and/or special duty nursing)
- Special Medical Foods
- Substance Use Disorder services, Inpatient
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)
- Transcranial Magnetic Stimulation
- Virtual Colonoscopy
- Wireless Capsule Endoscopy

For Multiplan Providers, you will be responsible for obtaining **Prior Authorization** when required. If you obtained Covered Services from a MultiPlan Provider and obtain **Prior Authorization** when required, benefits will be administered at the higher level of benefits.

Case Management Program

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

PresRN

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

Federal and State Health Care Reform

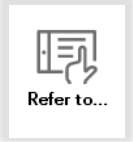
Presbyterian Health Plan shall comply with all applicable state and federal laws, rules and regulations. In addition, upon the compliance date of any changes in law, or the promulgation of any final rule or regulation which directly affects Presbyterian Health Plan's obligations under this *Summary Plan 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 and Coverage.*

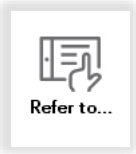


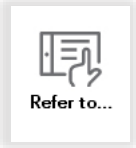
Copayment

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

Calendar Year Deductible (January 1 – December 31)

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



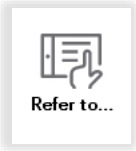


For Single and Two-Party Coverage, each Member must meet the applicable individual Deductible as outlined in the *Summary of Benefits and Coverage*. For Family Medical Coverage, an entire family meets their applicable Deductible when the total Deductible amount for all family Members reaches the applicable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

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

Coinsurance

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



Out-of-pocket Maximum

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

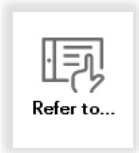
The Calendar Year Out-of-pocket Maximum includes the Deductible, Copayments and Coinsurance amounts listed in the *Summary of Benefits and Coverage*. Penalty amounts, non-covered charges, and any amounts over Medicare allowable charges are **not** included in the Out-of-pocket Maximum.

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

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

Family Out-of-pocket Maximum

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



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

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

Maximum Overall

There is no Lifetime maximum payment under the Plan. However, certain benefits are specifically limited and have maximum limits per Calendar Year or lifetime, as described in the *Summary of Benefits and Coverage* 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 Physician;
- It is the most appropriate supply or level of service, taking into consideration:
  - Potential benefits;
  - Potential harms;
  - Cost, when choosing between alternatives that are equally effective;
  - Cost-effectiveness, when compared to the alternative services or supplies;
- It is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- It is not for the convenience of the Member, the treating Physician, the Hospital, or any other healthcare Provider.

Presbyterian Health Plan determines whether a healthcare service or supply is Medically Necessary and, therefore, whether the expense is Covered. (**Note:** If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any item or service, you may file a Grievance or complaint. You may also request an external review of Presbyterian Health Plan's decision at any time. See "Grievance Procedures" in 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 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 what the insurance company will be charged for the tests
- Always review the explanation of benefits (EOB) you receive from Presbyterian Health Plan. If there are any discrepancies, call one of our Customer Service Center Representatives
- Be very cautious about giving information about your insurance coverage over the telephone

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

Eligibility, Enrollment, Effective Dates, and Termination Dates Summary

This is a summary of the NMPSIA Rules and Regulations. Complete Rules and Regulations are available by visiting nmpsia.com. NMPSIA Rules and Regulations supersede information contained in this summary.

Membership Information

Eligible Employee

You are eligible to participate in the New Mexico Public Schools Insurance Authority (NMPSIA) Employees Benefits Program if you are actively at work and work the minimum qualifying number of hours established by your employer. (In most cases, employees qualify for basic life insurance coverage because they work 15 hours or more per week. In most cases, employees qualify for all other lines of coverage because they work a minimum of 20 or more hours per week. If you work fewer than 20 hours per week but at least 15 hours per week, you may also be eligible to participate if your employer has passed a part-time employee resolution which has been approved by the NMPSIA Board of Directors).

If you are eligible, you may participate only in the lines of NMPSIA employee benefits coverage offered by your employer. Independent contractors (with the exception of one-bus owner operators) and fleet bus drivers are **not** eligible to participate in the NMPSIA Employee Benefits Program).

You have 31 days from your date of hire to apply for all other lines of coverage. We will consider that you have applied when you complete, sign, and turn in your application to your employer's benefits office, or when you or your employer enter your enrollment on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com. NMPSIA does **not** accept retroactive effective dates, so please apply for coverage prior to the effective date being requested.

In most cases, all other lines of NMPSIA coverage will become effective on the first day of the month following the day you apply provided you are actively at work on your effective date of coverage (and your premium is withheld and/or adjusted from your payroll check). Your effective date of coverage is determined by your employer based on your payroll deductions, but this coverage can never go into effect retroactively and never any sooner than the first day of the month **following** your first day actively at work. (For example, if your date of hire is August 2, September 1 is the soonest your coverage can go into effect.)

If you are a variable hour or seasonal employee (or a substitute), your employer determines if you are eligible for medical coverage under the Affordable Care Act guidelines. (*This classification of employees is only eligible for medical coverage*).

Board Member

Actively serving (publicly elected) board members of participating school districts or colleges/universities are eligible to enroll to the NMPSIA benefit plans. Board members have 31 days from being sworn into office to apply for benefits. Charter school board members are **not** eligible to enroll for NMPSIA Benefits.

Eligible Dependents

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

As a new hire, you are granted 61 days from the day your coverage goes into effect to provide the appropriate supportive documentation proving that your dependents are eligible for NMPSIA coverage. In cases of changes in status, you are granted 61 days from the qualifying event to provide the appropriate supportive documentation. In either case, coverage for your dependents will go into effect the first day of the month following the day you turn in the appropriate supportive documentation to your employer's benefits office, or uploaded, (provided you applied timely and meet the 61-day timeline for supportive documentation). The effective date of coverage for your dependents will **not** be made retroactive to your effective date of coverage, except for newborns and adopted children who are enrolled timely. See details below.

NEWBORN	CHILDREN PLACED FOR ADOPTION OR ADOPTED
You are granted 61 days from the first of the month following your newborn's birth to provide appropriate supportive documentation to your employer's benefits office.	You are granted 61 days from the first of the month following your child's date of placement for adoption or adoption (*whichever comes first*) to provide appropriate supportive documentation to your employer's benefits office.
Coverage for a newborn begins on the newborn's date of birth, provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your newborn, cannot be processed until you apply to enroll your newborn.	Coverage for an adopted child begins on date of placement or adoption (*whichever comes first*) provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.

If you are not enrolled in NMPSIA family medical coverage, your newborn will **not** be automatically covered from date of birth. You must apply to enroll your newborn within 31 days from the newborn's date of birth. If you miss this 31-day enrollment period, your newborn will not be eligible for coverage until January 1.	If you are not enrolled in NMPSIA family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 31 days from date of placement or adoption (*whichever comes first*) in order for your child's coverage to be effective from date of placement or adoption. If you miss this 31-day enrollment period, your child will **not** be eligible for coverage until January 1.

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

ELIGIBLE DEPENDENT	SUPPORTIVE DOCUMENTATION REQUIRED
Legal Spouse	Original official state publicly filed marriage certificate from the County Clerk's Office or from the Bureau of Vital Statistics (*chapel certificate is also acceptable*)
Domestic Partner (*Only if Employer has elected this option*)	Notarized affidavit of domestic partnership
Child under the age of 26 as follows:	
Natural Child or Stepchildren	Original official state publicly filed birth certificate from the Bureau of Vital Statistics (*hospital birth registration form is also acceptable*)
Legally adopted child or a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support	Evidence of placement by a state licensed agency, governmental agency or a court order/decree (*notarized statement and power of attorney are not acceptable*)
Child for whom you have legal guardianship	Legal Guardianship Document (*notarized statement and power of attorney documents are not acceptable*)
Foster child living in the same household as a result of placement by a state licensed placement agency, provided that the foster home is appropriately licensed	Placement order **and** foster home license
Dependent child with qualified medical child support order	Medical Child Support Order

Child enrolled in the NMPSIA Group Plan who reaches age 26 while covered under the NMPSIA Group Plan, who is wholly dependent on the eligible employee for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment	Evidence of incapacity and dependency in the form of a physician statement indicating diagnosis and prognosis and application must be provided 31 days before the child reaches age 26 or within 31-days from the date the child becomes incapacitated **while covered under the NMPSIA Group Plan** (*final determination is made by the insurance carrier*).

Ineligible Dependents

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

- Ex-spouses (even if stipulated in a final divorce decree)
- Common law relationships of the same or opposite sex which are **not** recognized by New Mexico Law unless domestic partner benefits are offered by your employer
- Dependents while in active military service
- Children left in the care of an eligible employee without evidence of legal guardianship
- Parents, aunts, uncles, brothers, sisters, or any other person not defined as eligible dependent under NMPSIA Rules
- Domestic partners unless your employer has elected this option

Enrollment Requirements

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

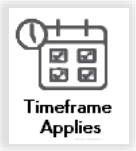
You may choose to apply to enroll in single coverage. If you choose to apply to enroll one eligible dependent, you must enroll ALL eligible dependents unless one of the following applies:

1. The eligible dependent for which you are requesting to exclude from a particular line of NMPSIA coverage is covered for that particular line of coverage under another plan (individual, group, Medicaid, Medicare, VA, Indian Health Services, etc.);
2. Your enrollment is due to a special event defined under the Special Enrollments provision; or
3. A divorce decree states that the ex-spouse is to provide a particular coverage for your dependent child.

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

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

Change of Status



If you (*or in some cases, your dependents*) have a change of status due to the following qualifying events, you must report this change in status by completing, signing, and turning a change card to your employer's benefits office **within 31-days** from the qualifying event (or when you and your employer enter your enrollment on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com).

Qualifying Events

- Birth
- Marriage
- Adoption of a child or child placement order in anticipation of adoption
- Incapacity of a child covered under the NMPSIA Group Plan
- Legal guardianship of a child
- Promotion to a new job classification with a salary increase, or employment status change from a part-time position to a full-time position with a salary increase (provided you are fulfilling the actively-at-work requirement)
- Divorce or Annulment (not a legal separation)
    - You cannot cancel a spouse when a divorce is in progress.
    - You are required to cancel an ex-spouse effective on the last day of the month your divorce becomes final (you will be required to provide certain pages of your final divorce decree or proof the divorce became final).
    - If you lose other health insurance coverage as a result of divorce, you may apply to enroll in the coverage(s) lost by providing the appropriate supportive documentation listed under the next bullet point.
- Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage (This may include an involuntary loss of medical insurance, dental insurance, vision insurance, exhaustion of COBRA, etc.)

IMPORTANT: You will be required to provide your employer's benefits office with a loss of coverage letter specifying who lost coverage, what type of coverage was lost, what day coverage was lost, and why coverage was lost. If the letter does not address each of these factors, we cannot determine the loss of coverage to be an involuntary loss of coverage and your enrollment may **not** be accepted.

- Loss of employment (including retirement)
- Establishment of termination through affidavit terminating domestic partnership
- Establishment of an affidavit of domestic partnership (If this option is available through your employer and provided all requirements listed in the affidavit apply.)
- Death

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

You must request enrollment **within 31 days** after your other coverage involuntarily ends. Exception: You have **60 days** from the date of involuntary loss of Medicaid coverage or the Children's Health Insurance Program (CHIP) to apply.

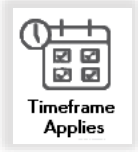
Special Enrollment Events for Medical Coverage Only

Special enrollment events mandated by state and federal laws permit you to apply to enroll in medical coverage **within 31 days** from the occurrence of a special event.

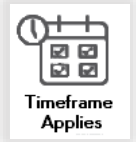
If you meet eligibility requirements for medical coverage and **are not enrolled in the NMPSIA Medical Plan**, you may enroll yourself only, or yourself and one or more eligible dependents for NMPSIA medical coverage **within 31 days** from the occurrence of the following special events:

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

To report your change of status due to a qualifying event or a special enrollment event you are required to complete, sign and turn in a change card and supportive documentation, or you and your employer may enter your change and upload the supportive documentation on the NMPSIA online enrollment system at https://nmpsiaonline.nmpsia.com **within 31 days** from the date of your qualifying or special event. If you do not meet this **31-day** deadline, you may apply for coverage during the established open enrollment in the fall with an effective date of Jan. 1.



Further, if you do not report a change of status that causes your spouse or child to become ineligible either **within 60 days** from the qualifying event or **within 60 days** from the day coverage would end; your spouse or child will **not** be eligible for COBRA continuation coverage under the NMPSIA Group Plan. When a spouse or child becomes ineligible, coverage under NMPSIA Group Plan ends for him/her on the last day of the month for which he/she becomes ineligible. (Even though you have **60 days** to report this change as it pertains to COBRA continuation coverage, NMPSIA Rules require that you report this change of status **within 31-days** from the qualifying event. This alerts NMPSIA to notify the carriers about your spouse's ineligibility to avoid unnecessary claim payments. This also allows your employer to make the necessary premium adjustments, if any, to your payroll check.)



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

Example #1: You divorce (or terminate your domestic partnership) on July 12th; this causes your ex-spouse (or ex-domestic partner) to become ineligible effective July 31st. You should immediately visit your employee benefits office to drop your ex-spouse (or ex-domestic partner) and any enrolled step-children (or your domestic partner's children), if applicable, from the NMPSIA Group Plan. Provide your employee benefits office with a copy of your divorce decree (or termination of domestic partner affidavit) and a "signed" record change card. Your ex-spouse (or ex-domestic partner) may apply for COBRA continuation coverage provided that you report this change of status within the time frame listed above.

(**REMINDER**: Review your beneficiary designation and make any changes you wish. Life insurance proceeds may not be payable to an ex-spouse unless the ex-spouse is re-designated as beneficiary after the divorce becomes final.)

When you are electing NMPSIA Group coverage, you will be required to complete, sign, and turn in the appropriate application, or you and your employer may enter your enrollment and upload the supportive documentation on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com. In the event of a dependent enrollment, your employer's benefits office is required to view the supportive documentation you have presented. Without the appropriate supportive documentation, your dependent's effective date of coverage will be delayed, if supportive documentation is not provided by the established deadline (**61 days** from your effective date or **61 days** from the qualifying event), your dependent will **not** be eligible for coverage until January 1).

Address and Phone Number Changes

In order for each insurance carrier affiliated with your NMPSIA coverage to process your address and/or phone number changes, you must report address and phone number changes

directly to your employer's benefits office on the appropriate form, or you may enter these changes online at https://nmpsiaonline.nmpsia.com.

Beneficiary Changes

You may change your beneficiary (as often as you wish) for your basic life insurance coverage and your additional life insurance coverage. Contact your employer's benefits office for a "Beneficiary Designation Form". Once you complete, sign, and turn in this form to your employer's benefits office, the form will be forwarded to NMPSIA's Eligibility/Enrollment Administrative Office. When a life claim is filed, the life insurance carrier verifies the latest beneficiary information in your membership file. (Be sure to designate a beneficiary for your basic life insurance coverage even if you decline or are not eligible to participate in the additional life coverage.) Visit https://go.standard.com/eforms/17041.pdf to view frequently asked questions about naming a beneficiary.

Termination of Coverage Effective Dates

Coverage terminates for NMPSIA Group participation as follows:

- **Employees** – Coverage terminates at the end of the period for which deductions are made from your payroll check. This termination date is determined by your employer.
- **Actively Serving Board Members** – Coverage terminates on the last day of the month in which the board member's term expires.
- **Dependents (spouse/domestic partner and dependent child)** – Coverage terminates on the last day of the month in which the eligible dependent becomes ineligible (i.e., coverage for an ex-spouse and step-children or the ex-domestic partner's children terminates on the last day of the month in which the divorce becomes final or domestic partnership terminates; coverage for any other dependent child ends on the last day of the month in which the child reaches the limiting age of 26).
- **Employees on an extended leave of absence (LOA)** – Your employer determines when your coverage ends under the active plan. Your employer's policy may allow you to remain on the active plan for up to one year from the date your LOA was approved, so be sure to contact your employer's benefit office one month prior to reaching this 12-month period to discuss your coverage options. **Also**, be sure to contact your employer's benefits office **within 31 days** from **returning from your LOA** to discuss your benefits or premiums that may have been suspended while you were on LOA. (Further, if you are on LOA due to disability, be sure to review information regarding benefits you may be eligible for under your life or disability coverage provided by The Standard.)

- **Open Enrollment** – NMPSIA offers open enrollment each fall for medical, dental, and vision coverage. Once you apply (prior to Jan. 1), the change becomes effective on Jan. 1.
- **Switch Enrollment** – NMPSIA offers switch enrollment each fall for medical coverage and for dental coverage. Once you apply (prior to Jan. 1) to switch plans, the change becomes effective on Jan. 1.
- **The No NMPSIA Double Coverage Rule** – If both of you and your spouse work for a NMPSIA employer, you and your spouse may not enroll each other as a spouse, nor may

you both cover your children. If your child is also an employee of a NMPSIA participating entity and enrolled for employee coverage, you may not cover your child as a dependent for the lines of coverage your child is enrolled as an employee. Double coverage outside of the NMPSIA Group Plan is allowed.

Covered Services

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

If you disagree with Presbyterian Health Plan's decision regarding the Medical Necessity of any 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 and Urgent Care

Accidental Injury and Medical Emergency Care

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

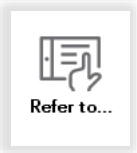
Definition of Emergency: Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected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

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

The Plan will provide reimbursement when a Member, acting in good faith, obtains emergency Medical Care for what reasonably appears to the Member, acting as a reasonable 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.



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

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

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

Urgent Care

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

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

Ambulance Services

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

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

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

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

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

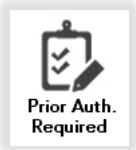
The Ambulance Copayment or Deductible and Coinsurance is waived if transportation results in an Inpatient Hospital Admission.

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

Bariatric Surgery

Surgical treatment of morbid obesity (bariatric surgery) is Covered only when prescribed by a licensed Provider, when Medically Necessary.

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



Cancer Clinical Trials

If you are a participant in a phase II, III, or IV approved Cancer Clinical Trial you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention and be designed to study the reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide Presbyterian Health Plan with notice of when the Member enters and leaves a qualified Cancer Clinical Trial.

The routine patient care costs that are covered must be the same services or treatments that would be covered as if you were receiving standard cancer treatment. Benefits also include FDA-approved Prescription Drugs that are **not** paid for by the manufacturer, distributor, or provider of the drug. Refer to **CVS Caremark** for information about your Prescription Drug benefits.

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

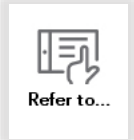
Chemotherapy, Dialysis and Radiation Therapy

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

Preventive Health Services

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



We will provide Coverage for Clinical Preventive Health Services without any Cost Sharing if you receive these services from our In-network Providers. If you receive these services from Out-of-network Providers you are responsible for the Out-of-network level Cost-Sharing amounts. Refer to your *Summary of Benefits and Coverage* for Out-of-network Cost-Sharing amounts.

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

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

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

You can review the recommended clinical preventive health services through the Presbyterian Website at https://www.phs.org/tools-resources/patient/Pages/preventive-care-guidelines.aspx.

Screening and Counseling Services

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

- Abdominal aortic aneurism screening for men ages **65 to 75 years** old with a history of smoking

- Prediabetes and Type 2 diabetes mellitus screening for adults ages **35 to 70 years** old who are overweight or obese
- Counseling for HIV, sexually transmitted infections (STIs) and domestic violence and abuse
- Falls prevention screening for adults **age 65** and older
- Hepatitis B screenings for persons at high risk of infection
- Hepatitis C screenings for adults age **18 to 79 years** old
- Latent tuberculosis screening for high risk populations
- Lung cancer screenings for **ages 50 to 80** with a history of smoking
- Preventive Physical Examinations
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam
- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a Low-Density Lipoprotein (LDL) level and a High-Density Lipoprotein (HDL) level
- Periodic stool examination for the presence of blood for all persons **45 years** of age or older
- One mammogram every **two years** to persons **age 40** and over
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:
    - Fecal occult blood testing (FOBT)
    - Flexible Sigmoidoscopy
    - Colonoscopy, including anesthesia services and polyp removal when performed as a screening procedure
    - Virtual Colonoscopy - Requires **Prior Authorization**
    - Double contrast barium enema

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

- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections and counseling, as well as counseling for drug and Tobacco use, healthy eating and other common health concerns
- Health education and consultation from Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members **19 years** of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive healthcare practices

- Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance use disorders will be Covered at No Charge to you, when obtained from a participating pharmacy. See your Plan's Covered drug list for details

Routine Immunizations

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

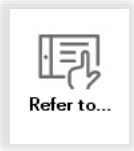
- The Advisory Committee on Immunization Practices Centers for Disease Control and Prevention
- The U.S. Preventive Services Task Force (USPSTF)
    - HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable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

Childhood Preventive Health Services

Childhood Preventive Health Services includes Coverage for Well-Child Care in accordance with the recommendations of the U.S. Preventive Services Task Force (USPSTF).

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

- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities
- Hearing and Vision screening for correction. This does **not** include routine eye exams or Eye Vision and Hearing screening to determine Refractions performed by eye care specialists. One Eye Refraction per Calendar Year is Covered for children under age six when Medically Necessary to aid in the diagnosis of certain eye diseases
- Pediatric Vision – Please refer to the Rider at the end of this Agreement for benefit coverage and details



- Prophylactic ocular topical medications for all newborns to prevent gonococcal ophthalmia neonatorum
- Behavioral Assessments
- Screening for Alcohol and drug use, anemia, blood pressure, congenital hypothyroidism, depression, developmental development and surveillance, dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, sexuality transmitted infections (STIs), newborn screening for Phenylketonuria (PKU), other genetic inborn errors in metabolism, and Tuberculin testing
- Skin cancer prevention behavioral counseling

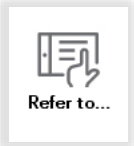
- Counseling from Providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. For Members under **19 years** of age, this includes (as deemed appropriate by the Member's Provider or as requested by the parents or legal guardian) education information on Alcohol and Substance Use Disorder, STIs and contraception
- Preventive benefits, as defined by the Affordable Care Act (ACA) for all recommended preventive services, including services related to pregnancy, preconception and prenatal care

Preventive Health Services for Women

With respect to women, evidence-informed preventive care and screenings provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Key preventive care includes but is not limited to:

- Well-woman visits to include adult and female-specific screenings and preventive benefits
- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for **one year** after delivery
- Cervical cancer screening for women ages **21 to 65 years** old
- Chlamydia and gonorrhea screenings for sexually active women ages **24 years** or younger and for older women at increased risk for infection
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, **not** including abortifacient drugs. Coverage for contraception is **not** subject to cost-sharing, utilization review, **Prior Authorization**, step-therapy requirements, or any other restrictions or delays on coverage.
    - Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please see the Presbyterian Pharmacy website at https://client.formularynavigator.com/Search.aspx?siteCode=0045707827
    - Coverage of a six-month supply of contraceptives at one time, provided that the contraceptives are prescribed and self-administered
- Counseling and screening for HIV, STIs and domestic violence and abuse
- Counseling interventions for pregnant and postpartum persons who are at an increased risk of perinatal depression
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active and pregnant women. For pregnant women, the screening will be covered at any point of the pregnancy, even those who present in labor with an unknown status
- Human Papillomavirus (HPV) DNA Test: High risk HPV DNA testing every **3 years** for women with normal cytology results who are 30 or older.

- HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP)
- Preeclampsia screenings in pregnant women throughout pregnancy
- Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breastfeeding counseling
- Sterilization services for women only. Other services, performed during the procedure, are subject to deductible and coinsurance as outlined in your *Summary of Benefits and Coverage*



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

Complementary Therapies

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

Acupuncture Services

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

Benefits for Acupuncture, including office calls, treatment, and Acupuncture are limited to 30 visits per Calendar Year in combination with benefits for chiropractic, massage therapy, naprapathy and rolfing services. In addition, for ancillary treatment modalities associated with Acupuncture Services, other Plan limitations may apply.

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 limited to 30 visits per Calendar Year limit in combination with benefits for acupuncture, massage therapy, naprapathy and rolfing services. In addition, for ancillary treatment modalities associated with chiropractic services, other Plan limitations may apply.

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 limited to 30 visits per Calendar Year in combination with benefits for acupuncture, chiropractic, naprapathy and rolfing services. In addition, for ancillary treatment modalities associated with massage therapy services, other Plan limitations may apply.

Naprapathic Services

Any Covered service of a Licensed Naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance.

Benefits are limited to 30 visits per Calendar Year in combination with benefits for Acupuncture, Chiropractic, Massage Therapy and Rolfing Services. In addition, for ancillary treatment modalities associated with naprapathic services, other Plan limitations may apply.

Rolfing

Rolfing must be provided by a certified rolfer.

Benefits are limited to 30 visits per Calendar Year in combination with benefits for Acupuncture, Chiropractic, Massage Therapy and Naprapathic Services. In addition, for ancillary treatment modalities associated with Rolfing Services, other Plan limitations may apply.

Biofeedback

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

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

COVID-19

As a Presbyterian Insurance Company member, there will be no cost to you for anything related to COVID-19 screening, testing, medical treatment, or vaccination. You will **not** pay Copays, Deductibles or Coinsurance for visits related to COVID-19, whether at a clinic, Hospital or using remote care. If you are on a high deductible plan (HDHP), these services will also be provided to you at no cost.

Dental Care and Medical Conditions of the Mouth and Jaw

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

Dental Accidents

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

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

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

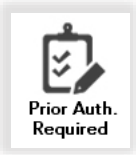
If craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders are a result of trauma such as a bodily injury or blow caused solely through external, violent, and unforeseen means, benefits are available for diagnostic examination, X-rays, medications, physical therapy, dental splints, Acupuncture,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

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

Hospitalization for Dental Care

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

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

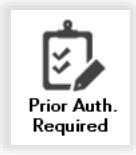


Oral Surgery and TMJ Treatment

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

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

Oral dental Surgery benefits require **Prior Authorization** only if admitted. In-network Providers request **Prior Authorization** for you. If you access care from an Out-of-network Provider or MultiPlan Provider, you will have to obtain **Prior Authorization,** when required. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Physician. Oral Surgery procedures that are covered by your dental carrier's coverage are provided *only* if a covered benefit under this



Plan. Benefits are payable based upon the Coordination of Benefits (COB) requirements set forth in 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

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

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

- **Insulin Pump Training** - one initial session and one follow-up session
- **Type I Diabetes.** For Members 18 years of age and under, up to six visits to normalize glucose within two months of diagnosis; thereafter, up to one visit per month as needed to maintain control of diabetes. For Members over 18 years of age, up to six visits to normalize glucose within two months of diagnosis; then up to one visit per month for the first year following diagnosis; thereafter, up to four visits per year
- **Type II Diabetes.** Up to four visits for initial education, plus if insulin is initiated, up to three visits for insulin start up and management; thereafter, up to four follow up visits per Calendar Year
- **Diabetes Occurring Only During Pregnancy ("Gestational Diabetes").** One initial visit; thereafter, two follow up visits per month. In addition, one visit within six months following delivery for conception counseling for patients planning additional children
- **Hypoglycemia and Glucose Intolerance.** Up to three visits to provide necessary nutritional counseling to delay or prevent onset of diabetes

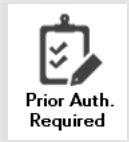
- **Additional visits** - include following a Physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; or visits when re-education or refresher training is prescribed by a healthcare Provider with prescribing authority

Diabetes supplies and services

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

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

Prior Authorization is also required for items costing more than $1,000 or more, or those requiring rental. For additional Diabetes Supplies, such as insulin needles and syringes, autolet, test strips, glucagon emergency kits, call CVS Caremark at **1-877-787-0652**.



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

Diagnostic Services

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

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology (Genetic test require **Prior Authorization**);
- Prenatal genetic testing unless it is determined to be Investigational (require **Prior Authorization**);
- Chromosome analysis, including karyotyping and molecular cytogenetic testing (require **Prior Authorization**);
- 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) (require **Prior Authorization**);

- Positron Emissions Tomography (PET) scans (require **Prior Authorization**);
- Home/Sleep disorders;
- Allergy testing; and
- CT scans (require **Prior Authorization**)

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

Durable Medical Equipment and Appliances, Hearing Aids, Medical Supplies, Orthotics and Prosthetics

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

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

pays 100% of the allowed amount up to a maximum of $2,200 every 36 months "per hearing impaired" ear, thereafter member pays 90% Coinsurance. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit.
    - All other members – hearing aid benefits are limited to a maximum of $500 in benefit payments during any 36-month period, thereafter member pays 90% Coinsurance. This benefit does **not** include coverage for a hearing test or any charge related to the fitting or prescribing of the hearing aid. The 36-month period is not based on a Calendar Year. The 36-month period begins on the date you purchase your first hearing aid and ends 36 months later. This benefit does include repair and replacement of hearing aids;
- Stethoscopes and manual blood pressure cuffs that are prescribed by a Physician. Automatic blood pressure cuffs or monitors are **not** covered unless the Member is physically unable to use a manual cuff; and
- Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member's condition, or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from Presbyterian Health Plan

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

Surgically implantable devices and prostheses are covered as follows:

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

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

Medical Supplies

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

- Colostomy bags, catheters;
- Gastrostomy tubes;
- Hollister supplies;

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

Prior Authorization from Presbyterian Health Plan is required for:

- Durable Medical Equipment, medical supplies (including enteral feeding tubes), orthopedics appliances, orthotics, and surgically implanted Prosthetics; and
- Any item costing $1,000 or more in total charges dispensed in the Physician'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)

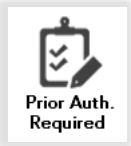
In-network Providers will request **Prior Authorization** for you. If you access care from an Out-of-network Provider or MultiPlan Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied.

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

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

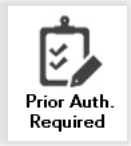
- Custom-Fabricated Orthotics/Orthosis except for knee-ankle-foot Orthosis (AFO and/or KAFO) devices for Members up to eight years old; and
- Duplicate equipment is **not** covered under this Plan.

Electroconvulsive Therapy (ECT)



Electroconvulsive Therapy (ECT) requires **Prior Authorization**.

Epidural Injections for Back Pain



Epidural corticosteroid injections are utilized in the treatment of disc-related diseases. Epidural injections for back pain require **Prior Authorization**.

Family Planning and Related Services

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

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

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

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

The above services are **the only infertility-related treatments** that will be considered for benefit payment. Infertility testing is covered only to diagnose the cause of infertility. **Once the cause has been established and the treatment determined to be non-covered, no further testing is covered**. This Plan will also cover testing related to one of the covered treatments,

listed above (such as lab tests to monitor hormone levels). However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a non-covered infertility treatment.

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

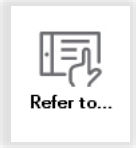
Genetic Inborn Errors of Metabolism Disorders (IEM)

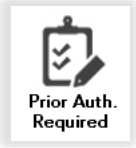
This benefit has one or more exclusions as specified in the Exclusions Section.

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

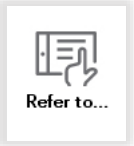
Covered Services include:

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



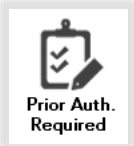


If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior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



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

Genetic/Genomic Testing



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

Habilitative Services

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

Autism Spectrum Disorder

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

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

Autism Spectrum Disorder Services must be provided by Providers who are certified, registered or licensed to provide these services. These services may require **Prior Authorization**.

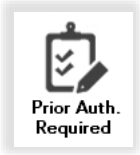
Limitation – Services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children **3 to 22 years** of age who have Autism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

Home Health Care Services

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

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

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



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

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

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

Hospice Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

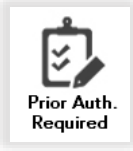
- Acute Inpatient Hospital care for curative services;
- Durable Medical Equipment;
- Non-Hospice care Physician visits; and
- Ambulance Services

Hospital Services – Inpatient

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

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

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



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

- Intensive Care Unit (ICU);

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

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

Blood

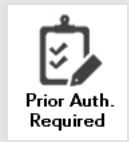
Benefits are available for blood transfusions, blood plasma, blood plasma expanders, and the charges for directed donor or autologous blood storage fees **if** the blood is to be used during a procedure that has been scheduled for that Member.

Physical Rehabilitation – Inpatient

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

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

Hyperbaric Oxygen Therapy



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

Infertility

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

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

Mental Health Services and Alcohol and Substance Use Disorder Services

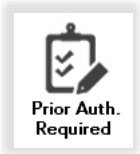
This benefit has one or more exclusions as specified in the Exclusions Section.

To obtain benefits for Outpatient Services related to Behavioral Health and Alcoholism 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 toll-free 1-800-453-4347, if you have any questions.

The following benefits and limitations are applicable for Behavioral Health and Alcoholism or Substance Use Disorder services. In all cases, Behavioral Health treatment and Alcoholism 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 Alcoholism and/or Substance Abuse only.

Outpatient services are available from the following credentialed Providers:

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

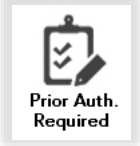


If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior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

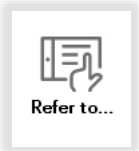
Mental Health Services

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

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



Partial hospitalization can be substituted for the Inpatient Behavioral Health Services Partial hospitalization is a non-residential Hospital-based day program attended by the Member at least 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 a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*



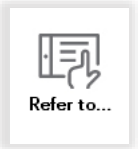
Outpatient, non-Hospital based short-term evaluative and therapeutic Behavioral Health Services will be provided based on medical necessity.

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

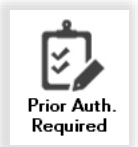
Outpatient services also consist of treatment including; individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Abuse for most Behavioral Health diagnoses. In addition, therapies for marriage, family and relationship problems,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

Alcohol and/or Substance Use Disorder Services

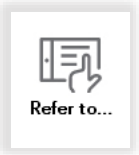
Benefits for Alcohol and or Substance Use Disorder are limited to the number of days listed in the *Summary of Benefits*. Inpatient services require **Prior Authorization** from Presbyterian Health Plan's Behavioral Health Department; failure to do so will result in benefits being reduced or denied.



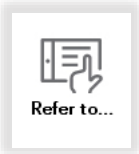
If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan Provider, then it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior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



Inpatient treatment in a Hospital or Substance 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 Calendar Year. If **Prior Authorization** is not obtained, the Member will be responsible for a $300 penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits*.



Partial hospitalization can be substituted for Inpatient 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.

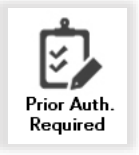


Outpatient, non-Hospital based intensive and standard Outpatient evaluative and therapeutic services for Alcohol and/or Substance Use Disorder will be covered.

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 Calendar Year listed in the *Summary of Benefits*. Intensive Outpatient Alcohol and/or Substance Use Disorder Services are defined as visits lasting up to nine hours per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes.

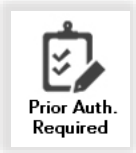
Coverage includes services for diagnostic tests, anesthetics, X-ray and laboratory examinations, and other care provided by a professional Provider, Hospital or Alcoholism treatment center.

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



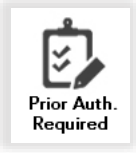
Outpatient services also consist of treatment including; individual, group or family counseling, medication management and neuropsychological testing for Behavioral Health and/or Substance Use Disorder for most Behavioral Health diagnosis. In addition, therapies for marriage, family and relationship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

Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems



Real-time continuous attended cardiac monitoring systems, such as Mobile Cardiac Outpatient Telemetry™ (MCOT™), are defined as a real-time, outpatient cardiac monitoring system that is automatically activated and requires no patient intervention to either capture or transmit an arrhythmia when it occurs. Mobile cardiac outpatient telemetry and real time continuous attended cardiac monitoring systems require **Prior Authorization**.

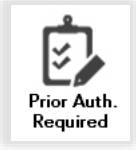
Non-emergency care when traveling outside the U.S.



Non-emergency care when traveling outside the U.S. requires **Prior Authorization**.

Nutritional Support and Supplements

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

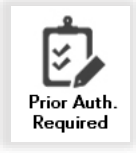


Nutritional supplements that require a prescription to be dispensed are Covered when prescribed by a Provider and when Medically Necessary to replace a specific documented deficiency. **Prior Authorization is required**.

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

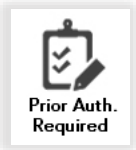
Enteral formulas or products, as Nutritional support, are Covered only when prescribed by an In-network Provider and administered by enteral tube feedings as a sole source of nutrition.

Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is Covered when ordered by a Provider.



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

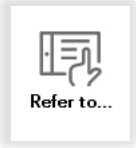
Orthotics



Pre-fabricated Orthotics requires **Prior Authorization**.

Outpatient Medical Services

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

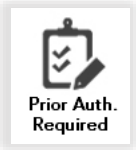


Outpatient Medical services include reasonable Hospital services provided on an ambulatory (outpatient) basis and those diagnostic and treatment procedures that are prescribed by your attending Provider. Refer to the **Prior Authorization Section** for services that require **Prior Authorization**.

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

- Chemotherapy and radiation therapy - Chemotherapy is the use of chemical agents in the treatment or control of disease
    - Treatment of malignant disease by standard chemotherapy;
    - Treatment of disease by X-ray, radium or radioactive isotopes
- Hypnotherapy **(Limited)** - Hypnotherapy is only Covered when performed by an anesthesiologist or psychiatrist, trained in the use of hypnosis when:
    - Used within two weeks prior to surgery for chronic pain management; and
    - For chronic pain management when part of a coordinated treatment plan
- Dialysis
    - Treatment for removal of waste materials from the body; including renal dialysis, hemodialysis, or peritoneal dialysis, the cost of equipment rentals and supplies; and
- Diagnostic Services – Refer to the **Diagnostic Services Section**
- Observation following Outpatient Services
- Sleep disorder studies, in home or outpatient facility
- Surgery
- Therapeutic and support care services, supplies, appliances, and therapies
- Wound care

Positron Emission Tomography (PET) Scans in an Outpatient Setting



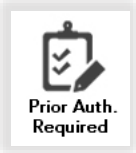
Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that quantifies biochemical processes in living tissue. Positron Emission Tomography (PET) scans in an outpatient setting require **Prior Authorization**.

Provider Services

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

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

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



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

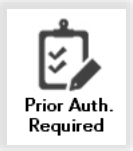
- Office visits provided by a qualified Provider
- Presbyterian Health Plan Video Visits provided online between a designated Provider and patient about non-urgent healthcare matters
- Presbyterian Health Plan Video Visits utilize Walmart Health Virtual Care nationwide network of Providers
- Telehealth appointments through video or phone are with a network Provider, including Presbyterian Medical Group Providers
- Online Visits are an online medical interview followed by a response from a Presbyterian Medical Group Provider
- Outpatient surgery and Inpatient surgery including necessary anesthesia services. Hypnotherapy is Covered as part of anesthesia preparation
- Hospital and Skilled Nursing Facility visits as part of continued supervision of Covered care
- Allergy Services, including testing and serum
- Sterilization procedures

- Second medical opinions. Cost Sharing will apply when you or your Provider requests the second medical opinion. Cost Sharing will not apply if we require a second medical opinion to evaluate the medical appropriateness of a diagnosis or service.

Prescription Drugs/Medications

Prescription Drugs/Medications are administered by CVS Caremark and can be reached at **1-877-787-0652**.

Proton Beam Irradiation

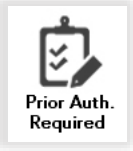


Proton beam therapy is a type of radiation therapy that utilizes protons to deliver ionizing damage to a target. Proton Beam Irradiation requires **Prior Authorization**.

Reconstructive Surgery

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

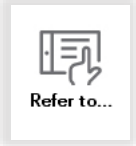
Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be provided if performed for the correction of functional disorders. For example, when a scar does not allow full function of a hand and a surgical procedure to remove the scar will achieve full function. Reconstructive Surgery requires **Prior Authorization**. For information regarding Reconstructive Surgery following a Mastectomy and Prophylactic Mastectomy, refer to the **Women's Healthcare Section**.



Rehabilitation and Therapy

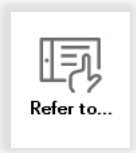
This benefit has one or more exclusions as specified in the Exclusions Section.

Cardiac Rehabilitation Services



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

Pulmonary Rehabilitation Services



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

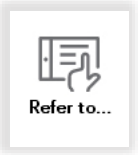
Short-term Rehabilitation Services

Short-term Rehabilitation benefits are available for physical therapy, occupational therapy, and speech therapy provided in a Rehabilitation Facility, Skilled Nursing Facility, Home Health Agency, or Outpatient setting. Short-term Rehabilitation is designed to assist you in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example, stroke, motor vehicle accident, or heart attack). Coverage is subject to the following requirements and **limitations**:

- Outpatient physical and occupational therapy require that your Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. Refer to your *Summary of Benefits and Coverage* for your Cost-Sharing amounts
- The treatment plans that define expected Significant Improvement must be established at the initial visit. Therapy treatments must be provided and/or directed by a licensed physical or occupational therapist
- Massage Therapy is only Covered when provided by a licensed physical therapist and as part of a prescribed Short-term Rehabilitation physical therapy program. Refer to your *Summary of Benefits and Coverage* for your Cost-Sharing amount
- Outpatient Speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is Covered when provided by a licensed or certified speech therapist

Coverage is subject to the following **limitations**:

- Your Provider must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition. Refer to your *Summary of Benefits and Coverage* for your visit limitations and Cost-Sharing amounts



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

Selected Surgical/Diagnostic Procedures

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

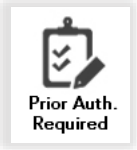
- Bariatric Surgery
- Blepharoplasty/Brow Ptosis Surgery
- Breast Reconstruction following Mastectomy
- Breast reduction for gynecomastia
- Cholecystectomy by Laparoscopy
- Endoscopy Nasal/Sinus balloon dilation
- Gender Confirmation Surgery
- Hysterectomy
- Lumbar/Cervical Spine Surgery
- Meniscus Implant and Allograft/Meniscus Transplant
- Panniculectomy
- Rhinoplasty
- Tonsillectomy
- Total Ankle Replacement
- Total Hip Replacement
- Total Knee Replacement

Skilled Nursing Facility Care

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

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

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



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 MultiPlan Provider, you will have to obtain **Prior Authorization**. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorizations** with your Physician before obtaining services.

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

Smoking Cessation Counseling/Program

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

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

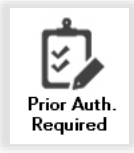
- Individual counseling at a Provider’s office is Covered under the medical benefit. The non-specialist Copayment applies

- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Provider. No Cost Sharing will apply and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services

For more information contact our Presbyterian Customer Service Center at **(505) 923-5600** or **1-888-275-7737**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711**.

In addition, benefits can be accessed through Express Scripts, your prescription drug Provider, and includes Nicorette or any other drug containing nicotine or other smoking deterrent medications. All prescription drug claims must be sent as separate claims to Express Scripts.

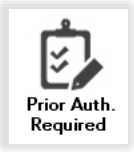
Special Inpatient Services



Special inpatient services (including but not limited to private room and board and/or special duty nursing requires **Prior Authorization**.

Transplants

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



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

Human Solid Organ transplant benefits are Covered for:

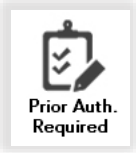
- Kidney
- Liver
- Pancreas
- Intestine
- Heart

- Lung
- multi-visceral (three or more abdominal Organs)
- simultaneous multi-Organ transplants – unless investigational
- pancreas islet cell infusion
- Meniscal Allograft
- Autologous Chondrocyte Implantation – knee only
- Hematopoietic Transplant Benefits are Covered for:
    - Bone Marrow Transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are Covered for the following indications:
        - Multiple myeloma
        - Leukemia
        - Aplastic anemia
        - Lymphoma
        - Severe combined immunodeficiency disease (SCID)
        - Wiskott Aldrich syndrome
        - Ewing's Sarcoma
        - Germ cell tumor
        - Neuroblastoma
        - Wilms Tumor
        - Myelodysplastic Syndrome
        - Myelofibrosis
        - Sickle cell disease
        - Thalassemia major

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

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

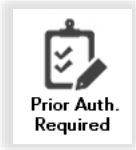
Wireless Capsule Endoscopy



Wireless capsule endoscopy is a noninvasive procedure in which a capsule containing a miniature video camera is swallowed. Capsule endoscopy is used as an adjunctive therapy in patients who have had an esophagogastroduodenoscopy (EGD) or colonoscopy, and these tests have failed to reveal evidence of disease or a source of bleeding. This procedure requires **Prior Authorization**.

Women's Healthcare

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



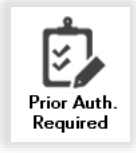
The following Woman's Healthcare Services, in addition to services listed in the Preventive Care Section are available for our female Members under the Women's Health and Cancer Rights Act (WHCRA). Inpatient Hospital services require **Prior Authorization**.

Obstetrical/Gynecological care includes:

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

Prenatal Maternity care benefits include:

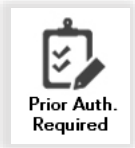
- Prenatal care
- Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus)
- Visits to an Obstetrician
- Certified Nurse-midwife
- Licensed Midwife
- Medically Necessary nutritional supplements as determined and prescribed by the attending Provider. Prescription nutritional supplements require **Prior Authorization**
- Childbirth in a Hospital or in a licensed birthing center

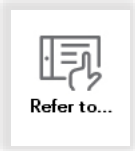


Maternity Care

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

- Maternity Coverage is available to a mother and her newborn (if a Member) for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a cesarean section. Maternity In-patient Hospital admissions and birthing center admissions require notification to appropriately manage care. Your provider will provide notification to the Health Plan of your maternity admission. Please see coverage for emergent/**Prior Authorization** admissions
- In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her attending Provider. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family Members or other support person(s) will be available to the mother for the first few days following early discharge
- Maternity Inpatient care in excess of **48 hours** following a vaginal delivery and **96 hours** following a cesarean section will be Covered if determined to be Medically Necessary by the mother's attending Provider. An additional stay will be considered a separate Hospital stay and requires **Prior Authorization**. Refer to your *Summary of Benefits and Coverage* for Cost-Sharing information



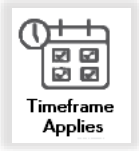


- High-risk Ambulance services are Covered in accordance with the **Ambulance Services Benefits Section**
- The services of a Licensed Midwife or Certified Nurse Midwife are Covered, for the following:
    - The midwife's services must be provided strictly according to their legal scope of practice and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

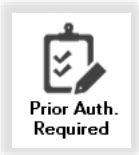
Newborn Care

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

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



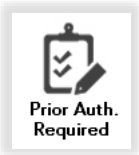
- If the above conditions are not met, we will **not** enroll the newborn for Coverage until the next Annual Group Enrollment Period
- Neonatal care is available for the newborn of a Member for at least **48 hours** of Inpatient care following a vaginal delivery and at least **96 hours** of Inpatient care following a Cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, it is considered a separate Hospital stay and requires **Prior Authorization**. Refer to your *Summary of Benefits and Coverage* for your Cost-Sharing amount.



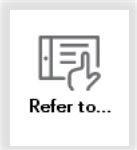
- Benefits for a newborn who is a Member shall include Coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant Coverage includes transportation, including air Ambulance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

Additional Women's Healthcare Benefits

- Mammography and Diagnostic Mammography Coverage
- Mastectomy, Prophylactic Mastectomy, Prosthetic Devices, Prophylactic Oophorectomy, Risk Reduction Surgery, and Reconstructive surgery. All care requires **Prior Authorization**
    - Coverage for Medically Necessary surgical removal of the breast (mastectomy) is for not less than **48 hours** of Inpatient care following a mastectomy and not less than **24 hours** of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless you and the attending Provider determine that a shorter period of Hospital stay is appropriate



- Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer is subject to Cost-Sharing amounts consistent with those imposed on other benefits. Refer to your *Summary of Benefits and Coverage* for Cost-Sharing amounts



  - Coverage is provided for external breast prostheses following Medically Necessary surgical removal of the breast (mastectomy). Two bras per year are Covered for Members with external breast prosthesis
  - As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance
  - Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy
- Osteoporosis Coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be Medically Necessary
- The Alpha-fetoprotein IV screening test for pregnant women, generally between 16 and 20 weeks for pregnancy, to screen for certain genetic abnormalities in the fetus
- Non-Invasive Prenatal Testing (NIPT)
- Coverage for the preventive screening of women who have family members with breast, ovarian, tubal or peritoneal cancers with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2)
- Women with positive screening results may receive genetic counseling and, if indicated after counseling, BRCA testing as determined by her healthcare provider

Limitations and Exclusions

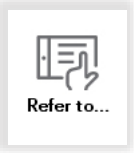
Please read this Section carefully. It explains the limitations that apply to certain Covered Services and specifies the Healthcare Services and supplies that are **not** covered under this Plan.

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

Limitations

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

- Some Benefits may be subject to dollar amount and/or visit **limitations**
- Benefits may be excluded if the services are provided by Out-of-network Providers
- Some Benefits may be subject to **Prior Authorization**



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

Acupuncture Services

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

Behavioral Health

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 Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan 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

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

Biofeedback

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

Chiropractic (Manipulations) Services

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

Cochlear Implants

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

Consumable Medical Supplies

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

Contact Lenses or Eyeglasses

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

Dental Prosthesis, Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Disorders

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

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

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

Diagnostic testing

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

Family Planning

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

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

- Hearing aids and the evaluation for fitting of hearing aids are covered for children under 18 years old (or under 21 years of age if still attending high school). The plan pays 100% of the allowed amount up to a maximum of $2,200 every 36 months "per hearing

impaired" ear, thereafter member pays 90% Coinsurance. This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit

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

Home Healthcare

Home healthcare 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 Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan 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

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

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

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

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 Services

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

Naprapathic Services

High Option are limited to a Calendar Year maximum benefit of 30 visits per Calendar year per Member for Covered Services, in combination with services provided for acupuncture, chiropractic, massage therapy and rolfing.

Low Option are limited to $500 Calendar Year maximum.

Services are covered In-Network only. Any Covered service of a Licensed Naprapathic, including hand manipulation of connective tissue, intended to release tension and restore structural balance.

Preventive services

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

Reconstructive Surgery

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 MultiPlan 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

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 MultiPlan 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

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

Rolfing Services

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

Routine Eye Screenings

Routine eye screenings are limited to Dependents through age 19.

Routine Hearing Screenings

Routine hearing screenings are limited to Dependents through age 19.

Skilled Nursing Care

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

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

Substance Use Disorder benefits are limited as follows: Services for any combination of Inpatient and Partial Hospitalization benefits is limited to 30 days per Calendar Year for Substance Use Disorder services, and there is a Lifetime Maximum of two courses of treatment for all services combined. Outpatient Services are limited to 30 visits per Calendar Year for Substance Use Disorder benefits. All Inpatient Services require **Prior Authorization** to be considered an eligible expense under this Plan

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

it is your responsibility to obtain **Prior Authorization**, when required. If you fail to obtain **Prior Authorization** when required, benefits will be administered at the Out-of-network level.

Lifetime maximum of 30 Inpatient days per year for Substance Use Disorder treatment for all services combined, including Inpatient and Outpatient Services.

Transplants

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

Exclusions

Any service, supply, item or treatment not listed as a Covered Service in 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:

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

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

Activities of Daily Living

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

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

Adoption/Surrogate

Adoption/Surrogate expenses are **not** a covered benefit.

Ambulance Services

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

Amniocentesis and/or Ultrasound

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

Artificial Conception

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

Autopsies are **not** a covered benefit under this Plan.

Before or After the Effective Date of Coverage

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

Behavioral Disorders

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

Behavioral Health and Alcoholism and/or Substance Use Disorder

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

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

Behavioral Training

Behavioral training is **not** a covered benefit under this plan.

Blood

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

Care for Military Service Connected Disabilities

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

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

Clinic or other facility services that the Member is eligible to have provided without charge. Examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to employment are **not** Covered.

Immunizations for the purpose of foreign travel are **not** Covered.

Clinical Preventive Health Services

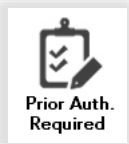
Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to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

Immunizations for the purpose of foreign travel are **not** Covered.

Clinical Trials

Any Clinical Trials provided, as well as those that do not meet the requirements indicated in the Benefits Section, are **not** Covered.

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



Services from Out-of-network Providers, unless services from an In-network Provider is not available and are **not** Covered. **Prior Authorization** is required for any Out-of-network Services.

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

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

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

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

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

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

If you are denied coverage of a cost and you contend that the denial is in violation of New Mexico Statutes Article 1978 59A-22-43, you may appeal the decision to deny the coverage of a cost to the superintendent, and that appeal shall be expedited to ensure resolution of the appeal within no more than **30 days** after the date of appeal to the superintendent.

Clothing or Other Protective Devices

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

Complementary Therapies

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

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

Complications of Non-benefit Services

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

Contact Lenses or Eyeglasses

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

Convalescent Care

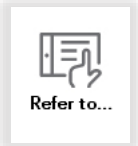
Convalescent care or rest cures.

Cosmetic Surgery

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

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

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



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

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

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

Costs for Extended Warranties and Premiums for Other Insurance Coverage

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

Counseling services

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

Court ordered services

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

Custodial Care

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

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

Dental Services

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

Dental implants are **not** Covered.

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

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

Dependent of Dependent (grandchild) expenses

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

Diabetes Services

Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses is **not** Covered, unless Medically Necessary due to diabetes or other significant peripheral neuropathies. Coverage of diabetes services requires medical diagnosis of diabetes from a licensed Provider. Equipment, appliances, prescription drug. Medications, insulin or supplies must have FDA approval and are the medically accepted standards for diabetes treatment, supplies and education.

Coverage for Diabetes Education must be:

- Medically necessary; or
- Due to a significant change in condition or symptoms; or
- When re-education is prescribed by a Provider; or
- Telephonic visits with a Certified Diabetes Educator (CDE) that are part of our In-network Providers who are registered, certified or licensed healthcare professional with recent education in diabetes management; or
- Related to medical nutrition therapy

Diabetes supplies and services:

- Must use approved brands
- Must be purchased at in-network pharmacy, preferred vendor or preferred durable medical equipment (DME) supplier
- Insulin pumps are covered only when medically necessary and when prescribed by an in-network endocrinologist
- Podiatric appliances for prevention of feet complications associated with diabetes must be medically necessary
- Must use preferred prescriptive diabetic oral agents, insulin, blood glucose monitors/meters, test strips for blood glucose monitors, and lancets and lancet devices according to the *Formulary*

Diagnostic Testing

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

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

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

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

Duplicate Coverage

Duplicate coverage including, but not limited to:

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

Duplicate Diagnostic Tests

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

Duplicate Equipment

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

Durable Medical Equipment, Orthotic and Prosthetic Devices and External Prostheses

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

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

Environmental Control

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

Exercise Equipment

Exercise equipment is not a covered benefit under this Plan.

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

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

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

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by state law, the drug or device is used for a purpose that is not approved by the FDA; or
- Testing is Covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient and if approved by the FDA. Routine genetic testing is **not** Covered; or
- For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in state law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, "Experimental" or "Investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials

Eye Exercises and Refractions

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

Food and Lodging Expenses

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

Foot Care

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

Functional Foot Orthotics

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 Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan 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

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 (or baldness)

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

Hearing Aids

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

Home Healthcare

Home healthcare benefits for care that:

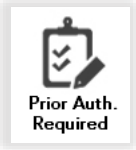
- Is provided primarily for the convenience of the Member or the Member's family;
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter; or
- Is provided by a nurse who ordinarily resides in the Member's home or is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

Certified Hospice Care Benefits

Certified Hospice Care Benefits are **not** covered for the following services:

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

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



Human Chorionic Gonadotrophin (HCG) Injections

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

Hypnotherapy

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

Implantation

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

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

Infertility services, listed below, are **not** covered.

- Prescription Drugs and Injections when provided by Provider
- Reversal of voluntary sterilization is **not** covered
- Donor sperm is **not** covered
- In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization are **not** covered
- Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue is **not** covered
- Prescription Drugs/Medications used in conjunction with In-vitro fertilization and artificial insemination are **not** covered
- Oral or injectable medications used to promote pregnancy are **not** covered

- Prescription Drugs, Medications or Devices used for the treatment of sexual dysfunction are **not** covered

Intradiscal Electrothermal Therapy (IDET)

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

Late Claims Filing

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

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

Legal Payment Obligations

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

Local Anesthesia

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

Long-term Rehabilitation

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

Maintenance or long-term therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice benefit period) is **not** covered under this Plan. In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Physician supporting

his/her opinion that your rehabilitative potential has not been reached. **Note**: Even if your rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations.

Massage Therapy

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

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

Medically Unnecessary Services

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

Membership Fees

Membership fees are **not** a covered benefit under this Plan.

Meniscal Transplants

Meniscal Transplant are **not** a covered benefit under this Plan.

Mobile or Temporary Testing Units

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

Non-covered Providers: Members of your immediate family or one normally residing in your home, health spas or health fitness centers, school infirmaries (except for Student Health Centers at institutions of higher education), private sanitariums, nursing homes, rest homes, or dental or medical departments sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

Non-human Organ Transplants

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

Non-medical Equipment

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

Non-medical Expenses

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

Non-prescription and Over-the-counter Drugs

Non-prescription 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.

Non-standard or Deluxe Equipment

Non-standard or deluxe equipment is not a covered benefit under this Plan.

Nutritional Support and Supplements

Nutritional Support and Supplements are not covered under this Plan unless the supplement is the sole source of nutrition. Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings is **not** covered.

Obesity Treatment

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

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

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 Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan 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

Orthoptics are **not** a covered benefit under this Plan.

Orthotripsy

Orthotripsy is **not** a covered benefit under this Plan.

Over-the-counter Contraceptive Medications and Supplies

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

Personal Convenience Items

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

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

Physical Examinations and/or Immunizations

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

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

Prescription Drugs

Prescription drugs obtained on an Outpatient basis are **not** covered under the medical portion of this Plan. If you have questions about your other Outpatient prescription drug benefits, contact CVS Caremark at **1-877-787-0652**.

Private-duty Nursing

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

Private Room Expenses

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

Protective Clothing or Devices

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

Radial keratotomy, LASIK

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

Reversals

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

Self-help Programs and Therapies

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

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

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

Speech Therapy

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

Sperm Storage

Sperm storage is **not** a covered benefit under this Plan.

Standby Professional Services

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

Surgical Sterilization Reversal

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

Thermography

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

Transplant Services

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

Travel and Other Transportation Expenses

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

Treatment for Injuries

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

Unreasonable charges will not be covered by this Plan.

Untimely Filing

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

Veterans Administration Facility Services

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

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

Vision Therapy

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

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

Vocational Rehabilitation Services

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

War-related Conditions

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

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

Work-related Illnesses or Injuries

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

- You fail to file a claim within the filing period allowed by the applicable law
- You obtain care not authorized by Workers' Compensation Insurance
- Your employer fails to carry the required Worker's Compensation Insurance

You fail to comply with any other provisions of the law.

Work-related Conditions

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

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

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

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

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

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

Claims

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

Emergency Services or Out-of-Network Providers

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

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

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

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

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

Out-of-Network Service Claims

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

Claims Outside the United States

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

Itemized Bills

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

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

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

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

Prescription Drug Claims

Claims for Prescription Drugs must be sent to the prescription drug Plan Administrator, **not** to Presbyterian Health Plan. Please refer to the CVS Caremark Schedule Plan Description or call them at 1-800-498-4904 for the claims filing procedures for Prescription Drugs.

How Payments are Made

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

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

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

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

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

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

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

Overpayments

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

Coordination of Benefits

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

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

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

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

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

2. Employee/Dependent. If the Member who received care is covered as the employee under one plan/coverage and as a Dependent under another, the employee’s coverage pays first. If

the Member is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a Dependent of an active employee, then the order of benefit determination is:

a. Benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent;
b. Medicare;
c. Benefits of the plan covering the Medicare beneficiary as the policyholder or as an active or retired employee

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

3. Dependent Child/Parents Not Separated or Divorced. If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first.

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

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

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

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

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

If you obtain services from an In-network Provider, they will request **Prior Authorization** from Presbyterian Health Plan, when required. If you obtain services from a MultiPlan 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 New Mexico Public Schools Insurance Authority 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. A person eligible under Medicare is defined as an employee or Dependent who is enrolled and covered under the voluntary portion (Part B) of Medicare, or who has been eligible to enroll under such part. All individuals who are eligible to enroll for Medicare Part B but have not done so, will be treated the same as all other persons eligible under Medicare and Presbyterian Health Plan will assume that eligible Members have Part B coverage. Plan benefits will be offset with Medicare Part B benefits whether or not the Member actually receives them.

Effect of Medicaid on Benefits

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

Subrogation

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

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

Assignment of Benefits

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

Fraudulent Application or Claim

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

Grievance Procedures

Overview

Many Grievances or problems can be handled informally by calling Presbyterian Health Plan at (505) 923-5600 or toll-free at 1-888-275-7737.

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

Any Grievance may be submitted orally or in writing. If you make an oral Grievance, our Customer Service Center will assist you to complete the required forms. **Please be advised that Presbyterian Health Plan shall not take any retaliatory action against you for filing a Complaint**. You may request a copy and detailed written explanation of the Grievance procedures by calling Presbyterian Health Plan at (505) 923-5600 or toll-free at 1-888-275-7737.

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

Adverse Determination Review Procedures

When you or your treating healthcare professional requests a healthcare service, Presbyterian Health Plan 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 Presbyterian Health Plan's initial review results in the denial, reduction or termination of the requested healthcare service, then Presbyterian Health Plan will notify you of the determination and of your right to request an internal review by Presbyterian Health Plan.

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

Presbyterian Health Plan
Grievance Department
P.O. Box 27489
Albuquerque, NM 87125
(505) 923-5600 or toll-free at 1-888-275-7737
Fax (505) 923-6111
E-mail: gappeals@phs.org

Presbyterian Health Plan's internal adverse determination Appeal review procedures require an initial review by a Presbyterian Health Plan 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 Presbyterian Health Plan's medical director decides to uphold the denial,

reduction or termination of the requested healthcare service, then Presbyterian Health Plan 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 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 Presbyterian Health Plan internally review the matter. First, a Presbyterian Health Plan representative will review the Grievance and provide you with a written decision within 15 working days from receipt of the Grievance.

NMPSIA 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 New Mexico Public Schools Insurance Authority 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.

Executive Director, NMPSIA
410 Old Taos Highway
Santa Fe, NM 87501
1-800-548-3724
Fax: (505) 983-8670

External Review by Superintendent of Insurance

If you are dissatisfied with the results of the internal review by Presbyterian Health Plan, the medical panel, or the NMPSIA, 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 Presbyterian Health Plan decision. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation commission, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689;
- E-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau at mhcb.grievance@state.nm.us; or
- Fax to the Superintendent of Insurance, Attention: Managed Health Care Bureau – External Review Request, at (505) 827-3833
- 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 Responsibilities

Your rights and responsibilities are important. By becoming familiar with your rights and understanding your responsibilities, an optimal partnership can be formed between you and your health plan. Above all, your relationship with your Provider is essential to good health. We encourage open communication between you and your Provider. Member rights and responsibilities regarding your health insurance can be found on the PHP/PIC website at https://www.phs.org/Pages/member-rights.aspx or by calling the Presbyterian Customer Service Center at (505) 923-5600 or toll free at 1-888-275-7737. **(TTY: 711)**.

Glossary of Terms

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

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.

Acute Medical Detoxification is a form of drug and alcohol abuse treatment in which a patient is weaned off their alcohol or drug addiction immediately with the help of medical supervision. It is a serious medical process that usually takes **three to five days**, depending on the substance.

Admission 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.

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Adverse Determination Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding an Adverse Determination.

Alcoholism means alcohol dependence or alcohol use disorder meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

Ambulance Service means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

Ambulatory Surgical Facility means an appropriately licensed provider, with an organized staff of Physicians that meets all of the following criteria:

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

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Calendar Year that is the most the Member will pay (Cost Sharing responsibility) for that Calendar Year.

Appeal means a request from a Member, or their representative, or a Practitioner/Provider who is representing a Member, to Presbyterian Insurance Company, Inc., for a reconsideration of an Adverse Determination (denial, reduction, suspension or termination of a benefit).

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

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

Authorization means a decision by a Healthcare Insurer that a Healthcare Service requested by a Provider or Covered Person has been reviewed and, based upon the information available, meets the Healthcare Insurer's requirements for Coverage and Medical Necessity, and the requested Healthcare Service is therefore approved. See **Certification**.

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

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

Biosimilar Drug is a biological product that is highly similar to an existing Food and Drug Administration approved product. It has no meaningful difference in terms of safety, purity, and potency.

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

Calendar Year means the period beginning January 1 and ending December 31 of the same year.

Calendar Year Out-of-Pocket Maximum means a specified dollar amount of Covered Services received during a benefit period that is the Member's responsibility.

Cardiac Rehabilitation means a program of therapy designed to improve the function of the heart.

Certification of Service means a determination by a health insurance carrier that a healthcare service requested by a healthcare professional or covered person has been reviewed and, based upon the information available, is a covered benefit and meets the carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care and effectiveness, and the requested healthcare service is therefore approved. The certification of service can take place following the health carrier's utilization review process.

Certified Nurse Midwife means any Person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

Certified Nurse Practitioner means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the board of nursing.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection or treatment of cancer.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent Person (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, Copyright 2013).

Coinsurance is a Cost Sharing method that requires a covered person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; co-insurance rates may differ for different types of services under the same health benefits plan.

Complaint means the first time we are made aware of an issue of dissatisfaction that is not complex in nature. For more complex issues of dissatisfaction see definition for **Grievance**.

Continuous Quality Improvement means an ongoing and systematic effort to measure, evaluate, and improve a health insurance carrier's processes in order to continually improve the quality of Healthcare Services provided to covered persons.

Conversion Subscriber means a Member who has converted to our non-Group (Individual Conversion) Membership as a Subscriber, pursuant to the Continuation of Coverage Section.

Copayment is a Cost Sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the Health Insurance carrier paying the allowed balance; there may be different Copayment amounts for different types of services under the same Health Benefits Plan.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means a copayment, co-insurance, deductible, or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the health benefits plan.

Coverage/Covered means benefits extended under this Agreement, subject to the terms, conditions, limitations, and exclusions of this Agreement.

Covered Benefits means those healthcare services to which a covered person is entitled under the terms of a health benefits plan.

Covered Person or Enrollee means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

Craniomandibular means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

Culturally and Linguistically appropriate manner of notice means the notice that meets the following requirements:

- The Healthcare Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language

- The Healthcare Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Healthcare Insurer

For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if 10% or more of the population residing in the county is literate only in the same non-English language, as determined by the Department of Health and Human Services (HHS). The counties that meet this 10% standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

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

Custom-fitted Fabricated Orthosis means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

Cytologic Screening (PAP Smear) means a Papanicolaou test or liquid based cervical cytopathology, a Human Papillomavirus Screening test and a pelvic exam for symptomatic as well as asymptomatic female patients.

Deductible means a fixed dollar amount that a covered person may be required to pay during a benefit period before the health insurance carrier begins payment for covered benefit; health benefits plans may have both individual and family deductibles and separate deductibles for specific services.

Dependent means any Member of a Subscriber's family who meets the requirements of the Eligibility, Enrollment and Effective Dates Section of this Agreement, who is enrolled as our Member, and for whom we have actually received an Application and the payment.

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Doctor of Oriental Medicine means a person licensed as a physician to practice acupuncture and oriental medicine with the ability to practice medicine and collaborate with other healthcare providers. A doctor of Oriental Medicine may serve as a Primary Care

Practitioner provided that they are 1) acting within his or her scope of practice as defined under the relevant state licensing law; 2) meets the Presbyterian Insurance Company eligibility criteria for healthcare practitioners who provide primary care; and 3) agrees to participate and to comply with Presbyterian Insurance Company's care coordination and referral policies.

Durable Medical Equipment means equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, hospital beds, crutches, and other medical equipment.

Elective Home Birth means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

Emergency Care means healthcare procedures, treatments, or services delivered to a Covered Person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a Reasonable Layperson, to result in:

- Jeopardy to the person's physical or mental health
- Safety of a fetus or pregnant person
- Serious impairment of bodily functions
- Serious dysfunction of any bodily Organ or part
- Disfigurement to the person

Emergency Medical Condition means the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention (including healthcare procedures, treatments, or services) could reasonably be expected by a reasonable layperson to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions, the presenting symptoms
- Serious dysfunction of any bodily organ or part, or
- Disfigurement to the person

Refer to **Reasonable/Prudent Layperson** definition in this Glossary.

Endorsement means a provision added to the Group Subscriber Agreement that changes its original intent.

Enrollee or Covered Person means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

Evidence-based Medical Literature means only published reports and articles in authoritative, peer-reviewed medical and scientific literature.

Excluded Services means Healthcare Services that are not Covered Services and that we will not pay for.

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

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

Eye Refraction means the measurement of the degree of refractive error of the eye by an eye care specialist for the determination of a prescription for eyeglasses or contact lenses.

Family, Infant and Toddler (FIT) Program means an early intervention services program provided by the Healthy Family and Children's Healthcare Services to eligible children and their families.

FDA means the United States Food and Drug Administration.

Formulary A drug *Formulary*, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgement of

physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. For the most up-to-date *Formulary* drug information visit http://docs.phs.org/idc/groups/public/documents/communication/pel_00236101.pdf

Generic Drug is a drug approved by the Food and Drug Administration as having the same active ingredient and may be substituted for the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental disability if untreated and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

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

Good Cause means nonpayment of premium, fraud or a cause for cancellation or a failure to renew which the Superintendent of Insurance of the state of New Mexico has not found to be objectionable by regulation.

Grievance means any expression of dissatisfaction from any Member, the Member's Representative, or a Practitioner/Provider representing a Member.

Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Practitioner/Provider, acting on behalf of that person with that person's consent, entitled to receive healthcare benefits provided by the healthcare plan
- An individual, or that person's authorized representative, who may be entitled to receive healthcare benefits provided by the healthcare plan
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Healthcare Purchasing Act.

Group means the legal entity which has contracted with us to obtain the benefits described in this Agreement for Subscribers and eligible Dependents, called Members, in return for periodic Prepayments specified in the Group Letter of Agreement (GLA).

Group Letter of Agreement (GLA) means the administrative agreement between us and the Group.

Group Subscriber Agreement (Agreement) means the booklet which describes the Covered Benefits for which the Member and his/her eligible Dependents (if any) are eligible for under the terms of the employer's Group Contract.

Habilitative Services means services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally.

Health Benefits Plan means a policy, or Agreement offered or issued by a Healthcare Insurer to provide, deliver, arrange for, pay for, or reimburse the costs of Healthcare Services.

Healthcare Facility means an institution providing Healthcare Services, including a Hospital or other licensed Inpatient center; an ambulatory surgical or treatment center; a Skilled Nursing Facility; a Residential Treatment Center, a Home Health Agency; a diagnostic laboratory or imaging center; and a Rehabilitation Facility or other therapeutic health setting.

Healthcare Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit healthcare plan, fraternal benefit society, vision plan, or pre-paid dental plan.

Healthcare Professional means a physician or other healthcare Practitioner, including a pharmacist or practitioner of the healing arts, who is licensed, certified or otherwise authorized by the state to provide Healthcare Services consistent with state law. See **Practitioner**.

Healthcare Services means a service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the health benefits plan, a physical or behavioral health service.

Hearing Aid means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

Hearing Officer, Independent Co-Hearing Officer or ICO means a healthcare or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and Coverage issues that arise in external review hearings.

Home Health Agency means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

Home Health Care Services means Healthcare Services provided to a Member confined to the home due to physical illness. Home Health Care Services and home intravenous services and supplies will be provided by a Home Health Agency at a Member's home when prescribed by the Member's Practitioner/Provider and we approve a **Prior Authorization** request for such services.

Hospice means a duly licensed facility or program, which has entered into an agreement with us to provide Healthcare Services to Members who are diagnosed as terminally ill.

Hospital means a facility offering inpatient services, nursing and overnight care for three or more individuals on a **24-hour**-per-day, **seven-days**-per-week-basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

Human Papillomavirus Screening means a test approved by the Federal Food and Drug Administration for detection of the Human Papillomavirus.

Identification Card (ID or Card) means the card issued to a Subscriber (Member) upon our approval of an Application that identifies you as a Covered Member of your Group Health Benefits Plan.

Immunosuppressive Drugs means Prescription Drugs/Medications used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include, but are not limited to:

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e., "autoimmune" diseases)
- Reducing inflammation
- Relieving certain symptoms
- Other times when it may be helpful to suppress the human immune response

Independent Quality Review Organization (IQRO) means an organization independent of the Healthcare Insurer or managed healthcare organization that performs external quality audits of Managed Healthcare Plans and submits reports of its findings to both the Healthcare Insurer and the managed healthcare organization and to the Division.

In-network Pharmacy means any duly licensed pharmacy, which has entered into an agreement with us to dispense Prescription drugs/Medications to our Members.

In-network Physician means any licensed Practitioner of the healing arts acting within the scope of his or her license who has entered into an agreement directly with us to provide Healthcare Services to our Members.

In-network Practitioner/Provider means a Practitioner/Provider who, under a contract or through other arrangements with us, has agreed to provide Healthcare Services to Covered Persons, known as Members, with an expectation of receiving payment, other than Cost Sharing, Deductibles, Coinsurance and/or Copayments, directly or indirectly from us.

Inpatient means a Member who has been admitted by a healthcare Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital. This may also be known as Hospitalization.

Long-term Therapy or Rehabilitation Services means therapies that the Member's Practitioner/Provider, in consultation with us, does not believe will likely result in Significant Improvement within a reasonable number of visits. Long-term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which Rehabilitation Services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome and Cerebral Palsy.

Malocclusion means abnormal growth of the teeth causing improper and imperfect matching.

Managed Care means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for Healthcare Services. Managed Care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services
- Contracts with selected healthcare Practitioner/Providers
- Financial incentives or disincentives for Covered Persons to use specific Practitioners/Providers, services, prescription drugs, or service sites
- Controlled access to and coordination of Healthcare Services by a case manager; and
- Payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care

Managed Health Care Plan (MHCP or Plan) means a Health Benefit Plan that we offer as a Healthcare Insurer that provides for the delivery of Comprehensive Basic Healthcare Services and Medically Necessary services to individuals enrolled in the plan (known as Members) through our own contracted healthcare Practitioners/Providers. This Plan either requires a Member to use, or creates incentives, including financial incentives, for a Member to use healthcare Practitioners/Providers that we have under contract. This Plan (Agreement) is considered to be a Managed Health Care Plan.

Maternity Benefits means covered benefits for prenatal, intrapartum, perinatal or postpartum care.

Medicaid means Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

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

Medical Drugs (Medications obtained through the medical benefit). A Medical Drug is any drug administered by a Healthcare Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a **Prior Authorization** and some must be obtained through the specialty network.

Medical Director means a licensed physician in New Mexico, who oversees our Utilization Management Program and Quality Improvement Program, that monitors access to and appropriate utilization of Healthcare Services and that is responsible for the Covered medical services we provide to you as required by New Mexico law.

Medical Necessity or Medically Necessary means Healthcare Services determined by a Provider, in consultation with the Health Insurance carrier, to be appropriate or necessary, according to:

- Any applicable generally accepted principles and practices of good medical care;
- Practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
- Any applicable clinical protocols or practice guidelines developed by the Healthcare Insurer consistent with such federal, national, and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical, or behavioral health condition, illness, injury, or disease

Medicare means Title 18 of the Social Security Amendments of 1965, *"Health Insurance for Aged and Disabled,"* as then constituted or later amended.

Member means the Subscriber or Dependent eligible to receive Covered Benefits for Healthcare Services under this Agreement. Also known as an Enrollee.

National Health Care Network means Out-of-network Practitioner/Providers, including medical facilities, with whom we have arranged a discount for Healthcare Service(s) provided out-of-state (outside of New Mexico).

Nurse Practitioner means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a Certified Nurse Practitioner pursuant to the Nursing Practice Act.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is Covered only when enteral tube feedings are required.

Observation Services means outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Practitioner/Providers written order. Our level of care criteria must be met in order to transition from Observation Services to an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient status. Medical criteria will also be considered. Observation for greater than **24 hours** will require **Prior Authorization** by the facility.

Obstetrician/Gynecologist means Physician who is eligible to be or is board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Organ means an independent body structure that performs a specific function.

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

Orthotic Appliance means an external device intended to correct any defect of form or function of the human body.

Out-of-network Practitioner/Provider means a healthcare Practitioner/Provider, including medical facilities, who has not entered into an agreement with us to provide Healthcare Services to our Members.

Out-of-network Services means Healthcare Services obtained from an Out-of-network Practitioner/Provider as defined above.

Out-of-pocket Maximum means the most that a Member will pay, in total Cost Sharing, during the Calendar Year. Once a Member has reached the Annual Out-of-pocket Maximum limit, we will pay 100% of the Medicare Allowable. The Annual Out-of-pocket Maximum includes Deductible, Coinsurance and Copayments. (Including **Self-Administered Specialty Drugs**) Cost Sharing and does not include non-covered charges including charges incurred after the benefit maximum has been reached. Covered charges for In-network Practitioner/Provider services do not apply to the Out-of-network Practitioner/Provider Annual Out-of-pocket

Maximum, and Covered charges for Out-of-network Practitioner/Provider services do not apply to the In-network Practitioner/Provider Annual Out-of-pocket Maximum.

Over the counter (OTC) means a drug for which a prescription is not normally needed.

Palliative Care means specialized medical care for people with serious illness. It is provided by an interdisciplinary team of clinicians and other specialists, who work with the member's other providers to provide an extra layer of support.

Personal Representative means a parent, guardian, or other person with legal authority to act on behalf of an individual in making decisions related to healthcare.

Presbyterian Health Plan Video Visit means a virtual visit with a contracted Walmart Health Virtual Care provider. These visits are scheduled through the myPRES portal.

PIC means Presbyterian Insurance Company, Inc., a corporation organized under the laws of the state of New Mexico.

PPACA means Patient Protection And Affordable Care Act.

PPO means Preferred Provider Organization.

Physician means any licensed Practitioner of the healing arts acting within the scope of his/her license.

Physician Assistant means a skilled person who is a graduate of a Physician Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Physician Assistants, and who is licensed to practice medicine, usually under the supervision of a licensed Physician.

Practitioner/Provider means any licensed Practitioner of the healing arts acting within the scope of his/her license.

Practitioner of the Healing Arts means a Healthcare Professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

Preferred (as it refers to medication and diabetic supplies) means medication that is selected for inclusion on Preferred tiers of the *Formulary* based on clinical efficacy, safety, and financial value.

Premium means the amount paid for a Contract of health insurance.

Prepayment means the monthly amount of money we charge payable in advance for Covered Benefits provided under this Agreement in accordance with the applicable Group Letter of Agreement (GLA) or non-Group Membership Letter of Agreement.

Prescription Drugs/Medications means those drugs that, by federal law, require a Practitioner's/Provider's prescription for purchase (the original packaging of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend, Caution: Federal law prohibits dispensing without a prescription or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

Primary Care Provider/Physician/Practitioner (PCP) means a Healthcare Professional who, within the scope of the professional license, supervises, coordinates, and provides initial and basic care to covered persons who may initiate their referral for specialist care, and who maintains continuity of patient care. Primary Care Practitioners shall include general Practitioners, family practice physicians, geriatricians, internists, pediatricians, and Obstetricians-Gynecologists, Physician Assistants and Nurse Practitioners. Pursuant to 13.10.21.7 NMAC, other healthcare professionals may also serve as primary care practitioners.

Prior Authorization means a pre-service determination made by a Health Insurance carrier regarding a covered person's eligibility for healthcare services based on medical necessity, health benefits coverage and the appropriateness and site of service pursuant to the terms of the health benefits plan.

Prosthetic Device means an artificial device to replace a missing part of the body.

Provider means a licensed Healthcare Professional, hospital or other facility authorized to furnish Healthcare Services.

Qualified High Deductible Plan means a plan that does not provide/pay benefits until the respective Deductible for that year has been satisfied. The Federal Government has established minimum Deductibles and maximum out-of-pocket limits for a plan to be considered qualified and thus, satisfy one of the requirements for members wishing to contribute to a Health Savings Account (HAS). Please contact your HSA administrator or financial institution for further information on eligibility for enrollment in or contribution towards an HSA.

Pulmonary Rehabilitation means a program of therapy designed to improve lung functions.

Reasonable/Prudent Layperson means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Healthcare Services. A Reasonable/Prudent Layperson is considered to have acted "reasonably" if, after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate

medical attention (including healthcare procedures, treatments, or services) could reasonably be expected to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part, or
- Disfigurement to the person

Reconstructive Surgery means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery

Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

Registered Lay/Licensed Midwife means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Rehabilitation Facility means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

Rehabilitation Services means Healthcare Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.

Remitting Agent means the person or entity designated by the Group to collect and remit the Prepayment to us.

Rescission of Coverage means a cancellation or discontinuance of Coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of Coverage has only a prospective effect: or
- The cancellation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums, Prepayments or contributions towards the cost of Coverage

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available **24 hours** a day.

Screening Mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic Members and includes the X-ray examination of the breast using equipment that is specifically for mammography, including the X-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film but does not include diagnostic mammography.

Self-Administered Specialty Drugs (Tier 5 Medications obtained through the Prescription Drug/Medication pharmacy benefit) Self-Administered Specialty Drugs are self-administered, meaning they are administered by the patient, a family member or caregiver. Self-Administered Specialty Drugs are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Most Self-Administered Specialty Drugs require **Prior Authorization** and must be obtained through the specialty pharmacy network. Self-Administered Specialty Drugs are often high cost, typically greater than **$600** for a **30-day** supply.

Self-Administered Specialty Drugs are not available through the mail order option and are limited to a **30-day** supply. Certain Self-Administered Specialty Drugs 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 Health Insurance Exchange Metal Level Plan *Formulary* list at www.phs.org. The medications listed on the *Formulary* are subject to change pursuant to the management activities of Presbyterian Insurance Company. You can call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5600**, or **1-888-275-7737**. Hearing impaired users may call **TTY 711**.

Service Area means the geographic area in which we are authorized to provide services as a Health Maintenance Organization and includes the entire state of New Mexico.

Short-term Rehabilitation means Rehabilitation Services and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected. See *Summary of Benefits and Coverage* for the number of visits.

Significant Improvement means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy; or
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record

Skilled Nursing Facility means an institution that is licensed under state law to provide skilled care nursing care services.

Smoking Cessation Counseling/Program means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow up
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance
- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities
- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program

Special Medical Foods means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM). These Special Medical Foods require **Prior Authorization** through Presbyterian's Pharmacy Department.

Specialty Pharmacy – Presbyterian's In-network Pharmacy vendor that, under contract or other arrangement with us, provides Covered **Self- Administered Specialty Drugs** to Members.

Spouse - Legally married husband or wife.

Subluxation (Chiropractic) means misalignment, demonstrable by X-ray or Chiropractic examination, which produces pain and is correctable by manual manipulation.

Subscriber means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual Contract, the Person in whose name the Contract is issued.

Substance Use Disorder means dependence on or abuse of substances meeting the criteria as stated in the DSM-5 for these disorders.

Summary of Benefits means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective subscriber or covered person by the Health Insurance Carrier.

Superintendent means The Superintendent of Insurance, the Office of the Superintendent of Insurance (OSI), or employees of OSI acting with the Superintendent's authorization.

Telemedicine means the use of telecommunications and information technology to provide clinical healthcare from a distance. Telemedicine allows healthcare professionals to evaluate,

diagnosis and treat patients in remote locations using telecommunications and technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver healthcare services to a site where the patient is located, along with the use of electronic media and health information. Telemedicine allows patients in remote locations to access medical expertise without travel.

Temporomandibular Joint (TMJ) is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

Termination of Coverage means the cancellation or non-renewal of Coverage provided by a Healthcare Insurer to a Covered Person/Grievant but does not include a voluntary termination by a Covered Person/Grievant or termination of the Health Benefits Plan that does not contain a renewal provision.

Tertiary Care Facility means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Tobacco means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas, and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and betel nut), and novel Tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

Total Allowable Charges means, for In-network Practitioner/Providers, the Total Allowable Charges may not exceed the amount the Practitioner/Provider has agreed to accept from us for a Covered service. For Out-of-network Practitioner/Providers, the Total Allowable Charges may not exceed Medicare Allowable Charge as we determine for a service.

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Covered Persons/Grievants to utilize preferred (In-network) Practitioners/Providers, to follow pre-authorization (**Prior Authorization**) rules, to utilize Prescription Drug Formularies or other cost-saving procedures to obtain Prescription Drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by a Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify/authorize or deny a requested Healthcare Service.

Urgent Care means a situation in which a Prudent/Layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

- The life or health of the covered person would otherwise be jeopardized;
- The covered person's ability to regain maximum function would otherwise be jeopardized;
- In the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or treatment;
- The medical exigencies of the case require expedited are; or
- The covered person's claim otherwise involves urgent care

Urgent Care Center means a facility operated to provide Healthcare Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Utilization Review means a system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

Vocational Rehabilitation means services which are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

Well-child Care means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

Women's Healthcare Practitioner/Provider means any Practitioner/Provider who specializes in Women's Healthcare and who we recognize as a Women's Healthcare Practitioner/Provider.

Acceptance Page

The New Mexico Public Schools Insurance Authority (NMPSIA) agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the NMPSIA PPO Medical Plan.

By: [Place Holder for Signature]

Date:

Ernestine Chavez
Deputy Director

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with use, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5600, 1-888-275-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-6111, or https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer.

You can also file a complaint with these state agencies:

Address: Managed Health Care Bureau
Office of Superintendent of Insurance
1120 Paseo De Peralta
Santa Fe, NM 87501

Phone: (505) 827-3811 or toll-free 1-855-427-5674

Online:* www.osi.state.nm.us

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Address: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501

Phone: (505) 490-4060 or toll-free 1-844-255-9210

Fax: (505) 490-4883

*To complete the online Consumer Complaint Form or to download the form in English or in Spanish, visit https://www.nmag.gov/consumer-complaint-instructions.aspx.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Address: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aviso de no discriminación y accesibilidad

La ley prohíbe la discriminación

Presbyterian Healthcare Services se compromete a prestar servicios de atención médica equitativos y existe con el fin de mejorar la salud de los pacientes, de los asegurados y de las comunidades que servimos. Valoramos la diversidad y la inclusión y nos esforzamos por tratar a todos con respeto. No discriminamos por motivos de raza; color; linaje; origen nacional (incluso por dominio limitado del inglés); ciudadanía; religión; sexo (incluso por embarazos, partos o problemas médicos conexos); estado civil; orientación sexual; expresión o identidad de género; estado de veterano; estado militar; estado de ausencia familiar o médica; edad; discapacidad física o mental; estado médico; datos genéticos; capacidad de pago; o cualquier otro estado protegido. Presbyterian proporcionará adaptaciones razonables y servicios de acceso al idioma a nuestros pacientes, asegurados y fuerza laboral.

Presbyterian Healthcare Services:

- Presta servicios y ayuda a las personas con discapacidades para que se puedan comunicar efectivamente, por ejemplo:
    - Intérpretes calificados de lengua de señas
    - Información escrita en otros formatos (letra grande, grabaciones de audio, formatos electrónicos accesibles y otros formatos)
- Proporciona servicios gratuitos de acceso al idioma a las personas cuyo idioma principal no es inglés, por ejemplo:
    - Intérpretes calificados
    - Información escrita en otros idiomas

Si necesita alguno de esos servicios, llame al Centro de Servicio al Cliente de Presbyterian al (505) 923-5600, 1-888-275-7737, TTY 711.

Si cree que Presbyterian Healthcare Services no le ha proporcionado dichos servicios o si cree que le han discriminado de alguna otra manera, puede presentar una reclamación a Presbyterian si llama al 1-866-977-3021, TTY 711, fax (505) 923-6111, o https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer.

Además puede presentar una queja formal referente a los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. electrónicamente en el portal de quejas de la Oficina de Derechos Civiles, que está a su disposición en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**,** o por correo o por teléfono al:

Además puede presentar queja a las agencias estatales siguientes:

Dirección: Managed Health Care Bureau
[Oficina de Atención Médica Administrada]
Office of Superintendent of Insurance

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[Oficina del Superintendente de Seguros]
1120 Paseo De Peralta

Santa Fe, NM 87501
Teléfono: (505) 827-3811 o gratis al 1-855-427-5674
En línea:* www.osi.state.nm.us

Dirección: State of New Mexico Office of the Attorney General
408 Galisteo Street, Villagra Building
Santa Fe, NM 87501
Teléfono: (505) 490-4060 o gratis al 1-844-255-9210
Fax: (505) 490-4883

*Para llenar el Formulario de Queja del Consumidor o para bajar el formulario a su computadora, ya sea en inglés o español, visite https://www.nmag.gov/consumer-complaint-instructions.aspx.

Dirección: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201
Número de teléfono (gratuito): 1-800-368-1019, 800-537-7697 (TDD)

Los formularios de quejas están a su disposición en **http://www.hhs.gov/**.

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Multi-Language Interpreter Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 505-923-5420, 1-855-592-7737 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 505-923-5420, 1-855-592-7737 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíilnih 505-923-5420, 1-855-592-7737 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 505-923-5420, 1-855-592-7737 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 505-923-5420, 1-855-592-7737 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 505-923-5420, 1-855-592-7737 (TTY: 711)。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: 505-923-5420، 1-855-592-7737 رقم هاتف الصم والبكم (TTY: 711).
Korean	주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 505-923-5420, 1-855-592-7737 (TTY: 711) 번으로 전화해 주십시오 .
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 505-923-5420, 1-855-592-7737 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。505-923-5420、1-855-592-7737 (TTY: 711) まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 505-923-5420, 1-855-592-7737 (ATS: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 505-923-5420, 1-855-592-7737 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 505-923-5420, 1-855-592-7737 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 505-923-5420, 1-855-592-7737 (TTY: 711) पर कॉल करें।
Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 505-923-5420، 1-855-592-7737 (TTY: 711) تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 505-923-5420, 1-855-592-7737 (TTY: 711).

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