City of Rio Rancho

Summary Plan Description and Guide to Your High Deductible Health Plan (HDHP) (PPO) Plan

Presbyterian Health Plan, Inc.

Group HDHP PPO Benefit Plans

HWP20010

Underwritten by Presbyterian Health Plan

Important Phone Numbers and Addresses

Presbyterian Customer Service Center

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

Phone:
(505) 923-5208 or
1-877-752-4164
TTY: 711 or 1-
877-298-7407

Prior Authorization

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

Phone:
(505) 923-5208 or
1-877-752-4164

Claims

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

Phone:
(505) 923-5208 or
1-877-4164

Appeals and Grievances

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

Phone:
(505) 923-5208 or
1-877-752-4164

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) 827-4253

Website

www.phs.org

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Summary of Benefits

The following are the Highlights of the City of Rio Rancho High Deductible Health Plan (HDHP) administered by Presbyterian Health Plan, Inc., (PHP) for City of Rio Rancho employees. These benefits are effective 7/1/23 through 06/31/24. The specific terms of coverage, limitations and exclusions are detailed in Sections 2, 4, and 5 of the Summary Plan Description.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	**In-network Limits**	**Out-of-network Limits**
ANNUAL CALENDAR YEAR DEDUCTIBLE - Customary Charges and additional charges incurred as a result of failure to obtain Prior Authorization are not counted towards the Deductible. There is no cross accumulation between In- and Out-of-network services.	Single $2,500 Double/Family $5,000	Single $5,000 Double/Family $10,000
ANNUAL OUT-OF-POCKET MAXIMUM Includes Annual Calendar Year Deductible Copayments and Coinsurance only – Does not include penalty amounts, charges above Reasonable and Customary, or non-Covered charges, including charges incurred after the benefit maximum has been reached. There is no cross accumulation between In- and Out-of-network services.	Single $2,500 Double/Family $5,000	Single $10,000 Double/Family $20,000
BENEFITS AND COVERAGE	**In-network Copayment/Coinsurance**	**Out-of-network Coinsurance**
PROVIDER SERVICES Including: • Office visits • Primary Care Provider • Video Visits • Specialist Home visits if Medically Necessary Outpatient surgery (in Provider's office) Medical Drugs [1] (injectable forms administered in Provider's office) Allergy Services • Testing • Serum (extracts) • Injections Injections such as insulin, heparin and injectable antibiotics	0% after Deductible	30% after Deductible

[1] Prior Authorization may be required. [2] Not subject to Deductible. [3] You are responsible for any balance due above Reasonable and Customary Charges. [4] 20% penalty applies if Prior Authorization is not obtained. [5] Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	In-network Copayment/Coinsurance	Out-of-network Coinsurance
PROVIDER SERVICES *(continued from previous page)* **Preventive Services** • Routine physicals • Well-child Care including vision and hearing screening (through age 26) • Immunizations • Adult Wellness • Health education programs	Covered at 100%[2]	30% after Deductible
Women's Preventive Services Contraceptive Methods • Intrauterine Devices (IUD) • Hormone Contraceptive Injections • Inserted Contraceptive Devices • Implanted Contraceptive Devices **Breastfeeding support, supplies and counseling (for one year after delivery)** Some infertility services including drugs and injections.[1] *See your SPD for full details.*	Covered at 100%[2]	30% after Deductible
On-campus Student Health Center	0% after Deductible	30% after Deductible
Hospital and Skilled Nursing Care visits	0% after Deductible	30% after Deductible
HOSPITAL SERVICES – Inpatient[1] Coverage includes: • Room and Board • Newborn delivery and other Hospital Obstetrical (OB) services • In-Hospital Provider visits, Surgeons, Anesthesiologist and other Inpatient services • Detoxification • Newborn care if discharged and re-admitted	0% after Deductible	30% after Deductible[4]

[1] Prior Authorization may be required. [2] Not subject to Deductible. [3] You are responsible for any balance due above Reasonable and Customary Charges. [4] 20% penalty applies if Prior Authorization is not obtained. [5] Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	In-network Copayment/Coinsurance	Out-of-network Coinsurance
MEDICAL SERVICES – Outpatient • Surgeries [(1)] (at facility) • Bariatric surgery [(1)], when Medically Necessary • X-ray and laboratory tests • PET [(1)]/CAT [(1)]/MRI [(1)] scans • Cardiac cath/ GI lab • Radiation therapy (non-surgical) • Chemotherapy Medical Drugs [(1)] Oral or inhalation forms/self-administered Medical Drugs [(1)] Intravenous (IV) Sleep Studies • Home • Outpatient Administration of blood/blood components	0% after Deductible	30% after Deductible[(4)]
RECONSTRUCTIVE SURGERY [(1)]	0% after Deductible	30% after Deductible
EMERGENCY ROOM CARE Including trauma services	0% after Deductible	0% after Deductible
URGENT CARE	0% after Deductible	0% after Deductible
AMBULANCE SERVICES- Including: Emergency or high-risk • Ground ambulance • Air ambulance Inter-facility transfer services • Ground ambulance • Air ambulance	0% after Deductible 0% after Deductible	0% after Deductible The member will be responsible for any balance due above Reasonable and Customary charges for out-of-network air ambulance service. 0% after Deductible The member will be responsible for any balance due above Reasonable and Customary charges for out-of-network air ambulance service.

[(1)] Prior Authorization may be required. [(2)] Not subject to Deductible. [(3)] You are responsible for any balance due above Reasonable and Customary Charges. [(4)] 20% penalty applies if Prior Authorization is not obtained. [(5)] Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	In-network Copayment/Coinsurance	Out-of-network Coinsurance
WOMEN'S HEALTHCARE Gynecological care In-office Obstetrical/Maternity Care/ Prenatal and Postnatal care Specialist (i.e., Perinatologist) Newborn Delivery and other Hospital Obstetrical (OB) services	0% after Deductible	30% after Deductible
DIABETES SERVICES Office visit and diabetes education Diabetic supplies or External Prosthetic Appliances [(1)] (Purchased through a Durable Medical Equipment supplier)	 0% after Deductible 0% after Deductible	 30% after Deductible 30% after Deductible[(4)]
COVERED MEDICATIONS Medical Drugs [(1)] Oral or inhalation forms/self-administered Medical Drugs [(1)] Intravenous (IV)	0% after Deductible	30% after Deductible
PRESCRIPTION DRUGS	**Administered by Express Scripts.** **Call Express Scripts at 1-866-217-3774**	
MENTAL HEALTH SERVICES [(1)] Outpatient Inpatient Partial Hospitalization	0% after Deductible	30% after Deductible
ALCOHOL AND SUBSTANCE USE DISORDER SERVICES [(1)] Detoxification • Outpatient • Inpatient Rehabilitation • Outpatient • Inpatient/Partial Hospitalization	 0% after Deductible 0% after Deductible	 30% after Deductible 30% after Deductible

[(1)] Prior Authorization may be required. [(2)] Not subject to Deductible. [(3)] You are responsible for any balance due above Reasonable and Customary Charges. [(4)] 20% penalty applies if Prior Authorization is not obtained. [(5)] Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	In-network Copayment/Coinsurance	Out-of-network Coinsurance
REHABILITATION AND THERAPY SERVICES Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 36 sessions intermittent ECG monitoring per Calendar Year) (copayment for Office Visit only - one copayment per day) Dialysis/Plasmapheresis/Photophoresis Pulmonary Rehabilitation (up to 24 sessions per Calendar Year) (copayment for the Office Visit **only** - one copayment per day)	0% after Deductible 0% after Deductible	30% after Deductible Not Covered
SHORT-TERM REHABILITATION [(1)] Physical Therapy • Inpatient • Outpatient (up to 80 visits per Calendar Year if Medically Necessary)[(5)] Occupational Therapy • Inpatient • Outpatient (up to 80 visits per Calendar Year if Medically Necessary) [(5)] • Speech and Hearing therapy (up to 24 visits per Calendar Year if Medically Necessary) [(5)]	0% after Deductible	30% after Deductible[(4)]
TRANSPLANTS [(1)]	0% after Deductible	50% after Deductible
COMPLEMENTARY THERAPIES[(5)] (Limited) Acupuncture services (up to 20 visits per Calendar Year if Medically Necessary) Chiropractic services (up to 20 visits per Calendar Year if Medically Necessary) Biofeedback for specific conditions	0% after Deductible 0% after Deductible 0% after Deductible	Not Covered Not Covered Not Covered
SKILLED NURSING FACILITY[(1)] (Up to 60 days per Calendar Year)[(5)]	0% after Deductible	30% after Deductible[(4)]

[(1)] Prior Authorization may be required. [(2)] Not subject to Deductible. [(3)] You are responsible for any balance due above Reasonable and Customary Charges. [(4)] 20% penalty applies if Prior Authorization is not obtained. [(5)] Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	In-network Copayment/Coinsurance	Out-of-network Coinsurance
HOME HEALTHCARE SERVICES [(1)] **HOME INTRAVENOUS SERVICES [(1)]** Services provided by an RN, LPN and other specified specialist Home intravenous services and supplies Medical Drugs [(1)] Oral or inhalation forms/self-Administered Medical Drugs [(1)] Intravenous (IV)	0% after Deductible	30% after Deductible[(4)]
HOSPICE CARE [(1)] • Inpatient • In home	0% after Deductible	30% after Deductible[(4)]
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[(1)] Hearing Aids (for school-aged children under age 18 or 21 years of age if still attending high school).	0% after Deductible Every 36 months per hearing-impaired ear.	30% after Deductible[(4)] Every 36 months per hearing-impaired ear.
EYEGLASSES AND CONTACT LENSES[(1)] Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus, or when related to Genetic Inborn Errors of Metabolism • Refraction eye exam associated with post-cataract surgery or Keratoconus correction	0% after Deductible	Not Covered
DENTAL SERVICES/ (CMJ/TMJ) (Limited)	0% after Deductible	30% after Deductible

[(1)] Prior Authorization may be required. [(2)] Not subject to Deductible. [(3)] You are responsible for any balance due above Reasonable and Customary Charges. [(4)] 20% penalty applies if Prior Authorization is not obtained. [(5)] Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

CITY of RIO RANCHO (HWP20010) BENEFITS AND COVERAGE	In-network Copayment/Coinsurance	Out-of-network Coinsurance
FAMILY, INFANT AND TODDLER PROGRAM Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Healthcare Services	No Copayment $3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits.	Not Covered

(1) Prior Authorization may be required. (2) Not subject to Deductible. (3) You are responsible for any balance due above Reasonable and Customary Charges. (4) 20% penalty applies if Prior Authorization is not obtained. (5) Visit limitation is combined between In-network and Out-of-network services. Refer to the Summary Plan Description for a more complete description of benefits.

Health Management

- Presbyterian Health Plan provides members a number of tools to help better manage all health conditions, including direct access to medical advice any time, day or night through PresRN Nurse Advice Line – **(505) 923-5570 or 1-866-221-9679**.
- Help with managing chronic conditions through Presbyterian Healthy Solutions Department – **(505) 923-5487** or **1-800-841-9705**.
- Useful online WebMD Health Manager site featuring up-to-date health information and resources to help create a personalized health improvement – **https://www.phs.org/tools-resources/patient/Pages/recommended-health-resources.aspx**.
- Useful diabetes education and support through our Certified Diabetes Educators. These resources are available through "Find a Doctor" on **www.phs.org**.

The City of Rio Rancho provides group healthcare coverage through the - High Deductible Health Plan (HDHP) administered by Presbyterian Health Plan, Inc.

Welcome

Welcome to Presbyterian Health Plan!

This Summary Plan Description (SPD) describes your group medical benefits. City of Rio Rancho offers this Preferred Provider Organization (PPO) Plan, hereafter referred to as the "Plan" or "Agreement."

This SPD is intended to provide you with easy-to-understand general explanations of the more significant provisions of your Plan effective July 1, 2023. Every effort has been made to make these explanations as accurate as possible. If any conflict should arise between this SPD and the Claims administrative procedures of our Third-Party Claim Administrator, Presbyterian Health Plan, or if any provision is not covered or only partially covered, the terms of this SPD will govern in all cases.

This SPD does not imply a contract of employment. City of Rio Rancho reserves the right to terminate, discontinue, alter, modify, or change this Plan/Agreement or any provision of this Plan/Agreement at any time.

It is your responsibility to read and understand the terms and conditions in this SPD. You are urged to read this SPD carefully and use it to make well-informed benefits decisions for you and your family.

Understanding This Summary Plan Description

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

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

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

Prior Authorization Required – This "**Prior Authorization**" symbol will appear next to those Covered Benefits that require our Authorization (approval) in advance of those services. To receive full benefits, your In-network 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 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 your receive care Out-of-network.

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

In addition, some important terms used throughout this Summary 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) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407**. 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) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407,** 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

Introduction

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

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

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

This 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 an In-network Provider.** City of Rio Rancho generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, City of Rio Rancho designates one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of the participating primary care providers, contact the Presbyterian Customer Service Center (PCSC) at **(505) 923-5208** or toll-free at **1-877-752-4164** Monday through Friday from 7 am. to 6 p.m. TTY users may call **711** or **1-877-298-7407**. **(505) 923-5208.** The PHP Provider Directory lists the In-network Providers.

In addition, PHP now contracts with National Network Provider, a national preferred Provider organization with over 3,500 acute care Hospitals and 400,000 practitioners. If you live or are traveling outside the State of New Mexico and require medical attention, we encourage you to see National Network practitioners and facilities. National Network Providers provide care to PHP Members at discounted rates, which help keep the cost of Medical Care down. In addition, you cannot be charged for any difference between what PHP pays the Provider and what the Provider charges beyond your appropriate Copayment and/or Deductible and Coinsurance (see **How the Plan Works** Section).

The National Network Provider directory is available through their website at **https://www.multiplan.us/** or you can contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5208** (in Albuquerque), or toll-free within New Mexico at **1-877-752-4164**. TTY users may call **711** or **1-877-298-7407.**

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, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5208** (in Albuquerque), or toll-free at **1-877-752-4164.** TTY users may call **711** or **1-877-298-7407.** It is best to call for clarification before services are rendered to ensure that the proper procedures are followed in order to afford you with the maximum level of benefits available under the Plan.

Member Rights and Responsibilities

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

As a Member of PHP, you have specific rights and certain responsibilities.

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

Member Rights

All Members have a right to:

- Be treated with courtesy, consideration, respect, and recognition of their dignity.
- Have their privacy respected, including the privacy of medical and financial records maintained by the Claim Administrator and its healthcare Providers as required by law.
- Be advised of the Claim Administrator's policies and procedures regarding products, services, Providers, and Appeals procedures, including detailed benefit information, and Member rights and responsibilities.
- Request and obtain information about any financial arrangements between the Claim Administrator and its Providers which might restrict referral or treatment options, or limit services offered to Members.
- Be told the details about what is covered, maximum benefits, what is not covered, what drugs or medicines are restricted, and how to obtain **Prior Authorizations,** when needed.
- Receive affordable healthcare, with limits on out-of-pocket expenses.
- Seek care from a Non-Participating Provider and be advised of their financial responsibility if they receive services from a Non-Participating Provider or receive services without required **Prior Authorization**.
- Be notified promptly of termination, decreases or changes in benefits, services, or the Provider network.
- Participate with Providers in decision making regarding their healthcare.
- Clear and candid discussion of Medically Necessary treatment options, regardless of benefit coverage or cost.
- Refuse care, treatment, or medications after the Practitioner has explained the care, treatment or other advice in language the Member understands.
- Refuse the care of a specific Practitioner.

- Be informed of the potential consequences of such refusal as outlined in this booklet.
- Have adequate access to qualified health professionals near where they live or work.
- Receive information from their Provider, in terms that they understand, including an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives irrespective of the Claim Administrator's position on treatment options.
- Have the explanation provided to next of kin, guardian, agent or surrogate if available, when the Member is unable to understand.
- Have all explanations to the next of kin, guardian, agent or surrogate recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member.
- Have access to services, when Medically Necessary, as determined by their primary or treating Provider, in consultation with the Claim Administrator, **24 hours** per day, **seven days** a week for urgent or Emergency Care services, and for other health services as defined by this booklet.
- Have access to translator services for Members who do not speak English as their first language, and translation services for hearing-impaired Members for communication with the Claim Administrator.
- Receive a complete explanation of why services or benefits are denied, a chance to appeal the decision to the Claim Administrator and to receive an answer within a reasonable time.
- Receive a Certificate of Creditable coverage when a Member's enrollment in this Plan terminates.
- Make complaints or Appeals regarding the Claim Administrator or the care provided.
- Continue an ongoing course of treatment for a period of at least **30 days** if the Member's Provider leaves the Provider network or if a new Member's Provider is not in the Provider network.

Member Responsibilities

All Members must:

Review this booklet and if there are questions, call the PCSC, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5208** (in Albuquerque), or toll-free within New Mexico at **1-877-752-4164** for clarification of benefits, limitations, and exclusions outlined in this booklet. TTY users may call **711** or **1-877-298-7407**.

- Provide, as much as possible, information that the Claim Administrator and Providers need in order to provide services or care or to oversee the quality of such care or services.
- Follow the Claim Administrator's policies, procedures, and instructions for obtaining services and care.
- Follow the plans and instructions for care that he/she has agreed upon with his/her Provider.
- Follow any instructions and guidelines given by a Provider. A Member may, for personal reasons, refuse to accept treatment recommended by Providers. A Participating Provider

may regard such refusal as incompatible with the continuance of the Provider-patient relationship and as obstructing the provision of proper Medical Care.

- Notify the Claim Administrator immediately of any loss or theft of his/her Identification Card.
- Refuse to allow any other person to use his/her Identification Card.
- Advise a Participating Provider of coverage with the Claim Administrator at the time of service. Members may be required to pay for services if they do not inform their Participating Provider of their coverage.
- Pay all required Copayments, Deductibles, and/or Coinsurance at the time services are rendered.
- Be responsible for the payment of all services obtained prior to the effective date of this Plan and subsequent to its termination or cancellation.
- Promise that all information given to the Claim Administrator in Applications for enrollment, questionnaires, forms or correspondence is true and complete.
- **Felony**: Claims for any period caused or contributed to by a Participant committing or attempting to commit an assault or felony, participating in an illegal occupation, actively participating in a violent disorder or not, or operating any vehicle while under the influence of any intoxicant. Actively participating does not include being at the scenes of a violent disorder or not while performing his or her official duties.
- **War**: Claims which arise out of, or are caused or contributed to by war or an act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

How the Plan Works

High Deductible Plan (HDHP)

Your group healthcare plan is a High Deductible Health Plan (HDHP). This HDHP is a reimbursement plan. Covered healthcare expenses are reimbursed based on Total Allowable Charges after Deductible and Coinsurances are paid. Everything is subject to the Deductible, which means you must satisfy the individual or family Deductible amount before this Plan begins paying. This includes retail pharmacy services. The only exception is Preventive Services

In-network Providers

As a Member of this HDHP, 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. However, most doctor visits and Hospital Admissions do require Coinsurance and/or Copayments at the time of service. Coinsurance is the percentage of covered charges that you must pay for Covered Services after the Deductible has been met. The amount of your Coinsurance for each service can be found in the *Summary of Benefits* of this document. The Coinsurance will be applied to the Total Allowable Charges or billed charges, whichever is less, for the particular procedure allowed by the Plan.

Provider Directory

You will find our In-network Practitioners/Providers close to where you live and work across the State. Our Provider Directory lists the In-network Practitioners, as well as In-network Hospitals, pharmacies, outpatient facilities and other healthcare Providers. The Provider Directory is available on our website at **https://www.phs.org/Pages/find-a-doctor.aspx**. If you need additional information about a Provider or would like to report an inaccuracy in the Provider Directory, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407**. Additionally, you may submit a Provider Directory inaccuracy report online at **https://www.phs.org/Pages/find-a-doctor.aspx** and by navigating to the identified Provider's details page and choosing the *Report Inaccuracies* option.

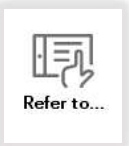
The Provider Directory is subject to change and you should always verify the Practitioner/Provider's network status by visiting our website at **https://www.phs.org/Pages/find-a-doctor.aspx**.

If our Provider Directory lists inaccurate information that you relied on in choosing a Provider, you will only be responsible for paying your In-network Cost-sharing amount for care received from that Provider. Please refer to the **Summary of Health Insurance Grievance Procedures Section** to understand your rights for filing an appeal.

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 routine care from Out-of-network Providers, payments by Presbyterian Health Plan for Covered Services will be **limited** to Reasonable and Customary Charges. For care other than Emergency or Urgent Care, you will be responsible for any balance due above the Reasonable and Customary 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 **Claims** Section of this document for more information on submitting such a claim.

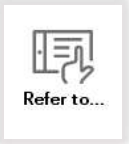


Some services are **Not Covered** when received from Out-of-network Providers. Please refer to your *Summary of Benefits* and throughout this document for a complete listing of Covered Services.

National PPO Providers

You can also obtain covered services outside of New Mexico from National Network Providers. Your Deductible, Copayment and/or Coinsurance will be the same as if you received the services from a Participating Provider. You can contact a Presbyterian Customer Service representative to help you locate an out-of-state National Network Provider. However, National Network Providers are not considered "Participating Providers." If a covered service requires **Prior Authorization**, you are responsible to obtain that **Prior Authorization** before obtaining that covered service from Out-of-network Providers or National Network Providers. If you fail to obtain **Prior Authorization** when required, you will be responsible for a 20 percent penalty for covered services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

You will not have any claims to file or papers to fill out in order to be reimbursed for medical services obtained from Participating Providers and out-of-state National Network Providers.



Your participating Provider or out-of-state National Network Provider will bill us directly. However, most doctor visits and Hospital Admissions do require Copayment at the time of service. The amount of your Copayment for each service can be found in the *Summary of Benefits.*

For additional information regarding National PPO Providers or to see if you need a **Prior Authorization** for Out-of-network Services, please call our Presbyterian Customer Service Center prior to obtaining services Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407**.

Cost-sharing – Your Out-of-pocket Costs

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.*

Annual Contract 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.

For Single Coverage the Member must meet the applicable individual Deductible as outlined in the *Summary of Benefits*. If Family Coverage is elected, the entire Family Deductible must be met before benefits will be paid. One Family Member may satisfy the entire amount for the whole family.

Coinsurance

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

Annual Out-of-pocket Maximum

To protect you and your covered Dependents from the high cost of catastrophic illness, there is a maximum on the total Copayment or Coinsurance amount you must pay in a Calendar Year for Covered Services. This total amount is referred to as your Out-of-pocket Maximum. After your Out-of-pocket Maximum is reached, the Plan pays 100 percent up to Reasonable and Customary charges, for Covered Services for the remainder of that Calendar Year, up to the maximum benefit amounts. Please refer to your *Summary of Benefits* for your Plan's Individual and Family Out-of-pocket Maximum amounts.

The amounts are calculated as follows:

In-network: Out-of-pocket Maximum (OOPM) includes Deductible and Coinsurance amounts only, including Prescription. Does not include charges for non-Covered Services, any penalties and any additional benefit charges.

Out-of-network: OOPM includes only the Out-of-network Deductible and Coinsurance amounts for Covered Services, including Prescription. Does not include charges for Non-Covered Services, any penalties and any additional benefit charges such as expenses in excess of Reasonable and Customary amounts.

Out-of-pocket expenses accrued under the In-network Option do not accrue toward the Out-of-network Out-of-pocket Maximum and vice versa.

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.* **Note:** If a Member's individual out-of-pocket is met, no more charges incurred by that Member may be used to satisfy the family out-of-pocket.

The Out-of-Pocket Maximum is listed in the *Summary of Benefits* and includes only the Copayment and Coinsurance amounts listed in the *Summary of Benefits.* Penalty amounts, non-covered charges, any amounts over Reasonable and Customary Charges are **not** included in the Out-of-Pocket Maximum.

Changes to Calendar Year/Family 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.

To inquire about the status of your specific Annual Out-of-pocket Maximum, you may call our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164.** Hearing-impaired users may call **TTY 711** or **1-877-298-7407**.

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 a Presbyterian Health Plan Member Services Representative.
- Be very cautious about giving information about your insurance coverage over the telephone.

If you suspect fraud, please call the Presbyterian Customer Service Center at (505) 923-5208 or 1-877-752-4164.

Prior Authorization

This Section explains what Covered Healthcare Services require Prior Authorization before you receive these services and how to obtain Prior Authorization. This is not an exhaustive list. Further information can be obtained through your PCP or at our website at www.phs.org.

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**.

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

- In-network Provider - When accessing services from an In-network Provider, the In-network Provider is responsible for obtaining **Prior Authorization** from Presbyterian Health Plan before providing these services to you.
- Out-of-network Provider or National Network Provider Providers - If you obtain services from an out-of-state National Network Provider, you will have to contact Presbyterian Health Plan to obtain **Prior Authorization**, when required. You should discuss the need for **Prior Authorization** with your out-of-state National Network Provider. However, it will remain your responsibility to obtain **Prior Authorization** when required. Failure to do so may result in a penalty in addition to the Deductible and/or Coinsurance listed in the *Summary of Benefits.*

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 Coverage, **Prior Authorization** requirements apply to your family Members who are also covered persons.

Services That Require Prior Authorization In or Out-of-Network

Prior Authorization is required as outlined in the following sections. In-network Providers request **Prior Authorization** when needed. If you obtain services from an Out-of-network Provider, it is your responsibility to obtain the needed **Prior Authorization.** Failure to do so (for Out-of-network Providers) will result in benefits being reduced or denied.

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

If PHP 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 provision. Other Covered Services are paid as explained in the *Summary of Benefits* and the **Benefits** Section. If the Admission is not for a covered service, no payment is made.

Note: All Admissions for Behavioral Health and Alcoholism and/or Substance Use Disorder services require **Prior Authorization** from PHP's Behavioral Health Department **(1-800-453-4347).** Failure to obtain **Prior Authorization** may result in benefits being reduced or denied. For emergencies, PHP's 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 PHP with the approval of City of Rio Rancho. Contact the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5208** (in Albuquerque), or toll-free within New Mexico at **1-877-752-4164**. TTY users may call **711** or **1-877-298-7407**.

In addition to **Prior Authorization** for all Inpatient services, **Prior Authorization** is required for the following services. For certain services, **Prior Authorization** may be requested over the telephone.

If **Prior Authorization** is not obtained for the following services, benefits will be reduced or denied for all related services. Your In-network Provider will request Prior Authorizations for you. If you access care from an Out-of-network Provider, 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 (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the **Benefits** Section).

- All Hospital admissions, Inpatient non-emergent (listed under Hospital Services-Inpatient in the **Benefits** Section).
- Bariatric Surgery.
- Blood glucose specialized monitors/meters, including those for the legally blind.
- Bone growth stimulators.
- Clinical Trials (Investigational/Experimental) (listed under Clinical Trials in the **Benefits** Section).
- Certified Hospice Care.
- Computed Axial Tomography (CAT) scans in an outpatient setting (listed under Diagnostic and Imaging Services in the **Benefits** Section).
- Detoxification (acute requiring medical intervention).
- Durable Medical Equipment (listed under Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids in the **Benefits** Section).
- Electroconvulsive Therapy (ECT).
- Epidural Injections for Back Pain.
- Foot Orthotics (listed under Orthotic Appliances in the **Benefits** Section).
- Genetic Testing.
- Home Health Care Services/Home Health Intravenous Drugs (listed under Home Health Care Services/Home Intravenous Services and Supplies in the **Benefits** Section).
- Home uterine monitoring.
- Hospital Admissions.
- Hyperbaric Oxygen (listed under Hyperbaric Oxygen Therapy in the Benefits Section)
- Injectable Drugs, includes Specialty Medications and Medical Drugs (listed under Preventive Health Services for Women and also Practitioner/Provider Services in the **Benefits** Section).
- Insulin pumps.
- Magnetic Resonance Imaging (MRI) in an outpatient setting (listed under Diagnostic and Imaging Services in the **Benefits** Section).
- Mental Health Services - Inpatient, Partial Hospitalization and select outpatient services (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the **Benefits** Section).
- Mobile Cardiac Outpatient Telemetry and Real-Time Continuous Attended Cardiac Monitoring Systems.
- Newborn Delivery and Hospital Obstetrical services (listed under Maternity Care in the **Benefits** Section).
- Non-emergency care when traveling outside the U.S.
- Nutritional Supplements (listed under Nutritional Support and Supplements in the **Benefits** Section).
- Observation Services greater than **24 hours**.
- Organ transplants (listed under Transplants in the **Benefits** Section).
- Orthotics.
- Podiatric and Orthopedic Appliances.

- Positron Emission Tomography (PET) scans in an outpatient setting.
- Prescription Drugs/Medications.
- Prosthetic Devices (listed under Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices, Surgical Dressing Benefit, Eyeglasses/Contact Lenses and Hearing Aids and also Women's Healthcare in the **Benefits** Section).
- Proton Beam Irradiation.
- Reconstructive and potentially cosmetic procedures (listed under Reconstructive Surgery and also Women's Healthcare Services in the **Benefits** Section).
- Repair or replacement of non-rental Durable Medical Equipment.
- Selected Surgical/Diagnostic procedures:
    - Ankle Subtalar Arthroereisis
    - Blepharoplasty/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
    - Panniculectomy
    - Rhinoplasty
    - Tonsillectomy
    - Total Ankle Replacement
    - Total Hip Replacement
    - Total Knee Replacement
- Skilled Nursing Facility care.
- Special Inpatient services (including but not limited to private room and board and/or special duty nursing).
- Special Medical Foods (listed under Genetic Inborn Errors of Metabolism Disorders (IEM) and also Prescription Drugs/Medications).
- Substance Use Disorder Services, Inpatient (listed under Mental Health Services and Alcohol and Substance Use Disorder Services in the **Benefits** Section).
- Temporo/Craniomandibular Joint Disorders (TMJ/CMJ) (listed under Dental Services (Limited) in the **Benefits** Section).
- Transplant Services (listed under Transplants in the **Benefits** Section).
- Virtual Colonoscopy (listed under Clinical Preventive Health Services in the **Benefits** Section).
- Wireless Capsule Endoscopy.

Benefits

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

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

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

Medical Necessity

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 PHP's medical director to meet all of the following conditions:

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

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

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

Care Coordination and Case Management

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

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

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

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

Disease management health coaches work with you to help you better manage your chronic disease, such as Asthma, Coronary Artery Disease, Diabetes, or Hypertension. Care is focused on helping you identify self-management goals for improving management of your chronic disease.

PresRN

PHP 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 PHP Members. Please call **(505) 923-5570** or **1-866-221-9679**.

Health Management Programs

Our clinically trained Healthcare Professionals work with your Practitioners/Providers to help enhance your quality of life in three areas: Staying healthy, living with illness, and Getting

Better. We help you reach optimum health through Clinical Preventive Health Services (such as Screening Mammography and childhood immunizations) as well as with disease management for conditions such as asthma, depression, diabetes, smoking cessation, and high-risk pregnancies.

If you would like more information about these services, please call our Presbyterian Customer Services at **(505) 923-5208** or **1-877-752-4164** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711** or **1-877-298-7407**. Also, visit our website at **www.phs.org**.

Covered Benefits

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

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

Urgent Care

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 the Presbyterian 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.*

Emergency Healthcare Services

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 PHP is required. Please refer to the *Summary of Benefits* for emergency or Urgent Care facility Coinsurance. Treatment in a Provider's office or an Ambulatory Surgical Facility is also a benefit and is paid as any other illness.

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

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

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

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

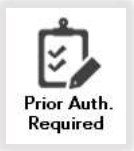
No notification or **Prior Authorization** is required for Out-of-network (including out-of-state) Hospitals or treatment facilities for Medical Emergency services. However, the Member will be responsible for the Deductible and Coinsurance as outlined in the *Summary of Benefits*.

A Member who, as a result of Emergency Health Services, is admitted to a non-Participating Hospital may choose to be transferred to a Hospital participating in the PHP Provider/Practitioner network. The Member must be stable and can be safely transferred. Refer to Ambulance Services in the *Summary of Benefits* for the required Coinsurance for inter-facility transportation costs. If the Member chooses to remain at an Out-of-network Hospital, Out-of-network benefits will apply.

Observation Services

Observation services are defined as Outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff which are reasonable and necessary to:

- Evaluate an outpatient's condition
- Determine the need for a possible admission to the Hospital
- When rapid improvement of the patient's condition is anticipated or occurs



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

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

Ambulance Services

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

Benefits are available for professional Ambulance Services if they are Medically Necessary to protect the life of the patient, and transportation is to the closest Hospital that can provide Covered Services appropriate to the patient'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 occurring during childbirth or delivery;
- Prenatal high-risk patients; and
- Provides for 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 is Medically Necessary and between medical facilities or results in an Inpatient Hospital Admission.

The Member will be responsible for any balance above Reasonable and Customary charges when Air Ambulance is provided by an out-of-network provider.

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

Bariatric Surgery

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

- Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 40 kg/m^2 or greater who are at high risk for increased morbidity due to specific obesity-related co-morbid medical conditions provided by an In-Network Provider; and
- Is a Covered Benefit only if a Member meets these criteria and all other requirements of this Agreement.

Member must have demonstrated adherence with all prescribed medications and treatment instructions. Appropriate documentation is required. Specific obesity-related co-morbidities include, but are not limited to:

- Cardiomyopathy
- Congestive heart failure with an ejection fraction of 50 percent or less than predicted
- Documentation of previous myocardial infarction requiring hospitalization
- Documented Type 2 diabetes mellitus
- Uncontrolled/massive leg lymphedema
- Obstructive sleep apnea with baseline AHI or RDI of 15 or greater, or currently under treatment with a positive pressure device (CPAP, BiPAP, C-Flex, etc.)
- Obesity-related osteoarthritis of the lower extremities for which joint replacement surgery of the knee or ankle has been recommended
- Pickwickian syndrome or cor pulmonale

Prior Authorization may be required.

Clinical Trials

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

If you are a participant in an approved cancer clinical trial that is being conducted in New Mexico, 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 PHP with notice of when the Member enters and leaves a qualified clinical trial.

Routine patient care costs are Covered for Members in a Cancer Clinical Trial if:

- The Cancer Clinical Trial is undertaken for the purposes of the prevention of or the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists.
- The Cancer Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology, and it has a therapeutic intent.
- The Cancer Clinical Trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention.
- There is not a non-Investigational treatment equivalent to the Cancer Clinical Trial.
- There is a reasonable expectation shown in clinical or pre-clinical data that the Cancer Clinical Trial will be at least as efficacious as any non-Investigational alternative.
- There is a reasonable expectation based on clinical data that the medical treatment provided in the Cancer Clinical Trial will be at least as effective as any other medical treatment.
- Pursuant to the patient's informed consent, Presbyterian is not liable for damages associated with the treatment provided during any phase of a Cancer Clinical Trail.

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

Certified Hospice Care

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

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

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

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

If the patient requires an extension of the benefit period, the Hospice agency must provide a new treatment plan, and the treating Provider must re-certify the patient's condition to PHP. 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 Provider benefits;
- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- Home health care by a home health aide;
- Physical therapy, speech therapy, or occupational therapy;
- Medical supplies; and

- Drugs and medications for the Terminally Ill Patient

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

- 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 **10 continuous days**. No more than two respite care stays are available during a six-month Hospice benefit period. *Respite care* provides a brief break from total care given by the family.

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

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

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

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

Chemotherapy/Dialysis/Radiation Therapy

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

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

Clinical Preventive Health Services

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

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

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

Cytologic Screening (Pap Smear Screening)

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

Health Education and Counseling

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

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

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

Mammography Coverage

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

- A baseline before age 50;
- One every one to two years for ages 50 and over; and
- As otherwise medically indicated

Prostate Exams

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

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

Routine Vision Screening

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

Routine Hearing Screening

Routine hearing screenings performed only by licensed Providers to determine the need for hearing correction are a benefit and are limited to screening only for Members through age 17. See additional coverage outlined later in this section under Hearing Aids.

Routine Immunizations

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

Routine Physical Examinations

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

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

- Ages 8-19, see Well-child Care (next page);
- Ages 20-39, an exam every five years;
- Ages 40-49, an exam every three years; and
- Ages 50 and over, an exam every two years

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

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

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

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

Childhood Preventive Health Services

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

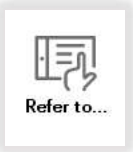
- During 1st year of age at 1, 2, 4, 6, 9, and 12 months;
- During 2nd year of age at 15, 18, and 24 months;
- Yearly check-ups for ages 3 and 4; and
- Every year for ages 3 through 18.

Preventive Health Services for Women

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

- Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery.
- Counseling for Human Immunodeficiency Virus (HIV), sexually transmitted infections (STIs) and domestic violence and abuse.
- Domestic and interpersonal violence screening and counseling for all women.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
    - Generic birth control (See Pharmacy benefits);
    - Intrauterine devices (IUD);
    - Hormone contraceptive injections;
    - Inserted contraceptive devices; and
    - Implanted contraceptive devices
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- HIV screening and counseling for sexually active women.

- Human Papillomavirus (HPV) DNA Test: high-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- Screenings and counseling for pregnant women, including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast-feeding counseling.
- STI counseling for sexually active women.
- Sterilization services for women only. Other services during procedure are subject to Deductible and Coinsurance as outlined in your *Summary of Benefits*.
- Well-woman visits to obtain recommended preventive services.



You do not need **Prior Authorization** from City of Rio Rancho or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining **Prior Authorization** for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact PHP at **(505) 923-5208**.

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

Complementary Therapies

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

Acupuncture

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

Benefits for Acupuncture, including office calls, treatment and Acupuncture, are limited as specified in the *Summary of Benefits,* in combination with chiropractic. 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 PHP.

Benefits are **subject to a Calendar Year limit** as shown in the *Summary of Benefits,* in combination with benefits for Acupuncture. In addition, for ancillary treatment modalities associated with chiropractic 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.

Massage Therapy (Limited) is only Covered when provided by a licensed physical therapist and as part of a prescribed short-term physical therapy program. See **Benefits** Section.

Benefits for covered biofeedback services, including office calls, are limited to the conditions listed above.

COVID-19

As a PHP 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 Services (Limited)

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 as a result 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. Dental prostheses may include the placement of dental implants to restore the area of trauma only if it is determined to be the most cost-effective restoration to normal form and function.

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 as a result of biting, chewing or malocclusion.

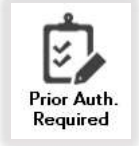
When alternative dental or surgical procedures or Prosthetic Devices are available, the dental accident benefit allowance is based upon the least costly procedure or Prosthetic Device.

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 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 Authorization** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorization** with your Provider. The dental procedure itself is not a covered benefit unless conditions for trauma or oral Surgery are met.

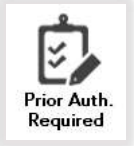


Oral Surgery and TMJ Treatment

Oral dental Surgery benefits are available for cutting procedures for diseases, such as:

- Removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required;
- 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);
- External or intraoral cutting and draining of cellulitis (inflammation) that extends beyond the dental space;
- Surgical correction of prognathism with handicapping malocclusion, a marked projection of the lower jaw that interferes with chewing;
- Removal of bony growths on the jaws and hard palate, unless done in preparation of the mouth for dentures;
- Incision of accessory sinuses, salivary glands, or ducts;
- 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, you will have to obtain **Prior Authorization** when required. Failure to do so may result in benefits being reduced or denied. Discuss the need for **Prior Authorization** with your Provider. Oral Surgery procedures that are covered by your dental carrier's coverage are provided only if a covered benefit under this Plan. Benefits are payable based upon the Coordination of Benefits (COB) requirements set forth in the **Effects of Other Coverage** Section of this booklet.



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

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

Diabetes Services

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

Diabetes Education (Limited)

Diabetes education is a covered benefit by referral and includes coverage for any Provider rendering education or instructional services for diabetes. When services are obtained from In-network Providers, the Copayment/Coinsurance 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 during pregnancy only ("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 Provider 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

When prescribed by the Member's Attending Provider, the following equipment, supplies, appliances and services are available from a Durable Medical Equipment supplier and are covered for Members with diabetes:

- Standard blood glucose monitors;
- Visual reading urine and ketone strips;
- Insulin;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Prescriptive oral agents for controlling blood sugar levels;
- Medically Necessary podiatric appliances for prevention 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 for prevention and treatment when **Prior Authorization** is obtained from Presbyterian Health Plan; and
- Insulin pumps when Medically Necessary and prescribed by an In-network endocrinologist

For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), see your Prescription Benefit administered by **Express Scripts**.

Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services.

Diabetes Supplies and Equipment – Pregnancy Related

The following 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 when Medically Necessary, prescribed by a participating endocrinologist;

- Medically Necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, when **Prior Authorization** is obtained from Presbyterian Health Plan, custom-molded inserts, replacement inserts, preventive devices, and shoe modifications; and
- Blood glucose monitors

Prior Authorization is also required for items purchased from a vendor and costing $500 or more. Your In-network Provider will request **Prior Authorizations** for you. If you access care from an Out-of-network Provider, you will have to obtain **Prior Authorization**. Discuss the need for **Prior Authorizations** with your Provider before obtaining any of the following services.

For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), see your Prescription Benefit administered by Express Scripts.

Diagnostic and Imaging Services

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

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

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

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

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

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

- The rental or, at the option of PHP, the purchase of Durable Medical Equipment when prescribed by a Provider 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;
- Custom-Fabricated knee-ankle-foot orthosis (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 Provider. (Duplicates are not covered, and replacement is covered only if a Provider or optometrist recommends a change in prescription due to the medical condition.);
- Hearing aids and the evaluation for fitting of hearing aids are covered for school-aged children under 18 years old (or under 21 years of age if still attending high school). This benefit includes the fitting and dispensing services, including ear molds as necessary to maintain optimal fit;
- Stethoscopes and manual blood pressure cuffs that are prescribed by a Provider. Automatic blood pressure cuffs or monitors are not covered unless the Member is physically unable to use a manual cuff; and
- Repairs or replacement of Durable Medical Equipment, prostheses, and orthotics when Medically Necessary due to wear, change in the Member's condition, or after the product's normal life expectancy has been reached and when **Prior Authorization** is obtained from PHP.

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 Prosthesis/Orthosis will be based upon the least costly item.

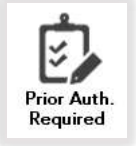
Medical Supplies

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

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

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



In-network Providers request **Prior Authorization** for you. 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.

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;
- 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 knee-ankle-foot orthoses (KAFO), and ankle-foot orthoses (AFO) are Covered for our Members in accordance with federal coverage guidelines; and
- Duplicate equipment is not covered under this Plan.

Family Planning and Related Services

Family planning services are covered for the following procedures:

- Injection of Depo-Provera for birth control purposes;
- Diaphragm, including fitting;
- Birth control devices, including surgical implantation and removal;
- Intrauterine Devices (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 (Mifeprex) administered by a Provider

Infertility diagnosis and treatment, including drugs and injections administered in the Participating Provider's office and approved by PHP in accordance with accepted medical practice for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery. Artificial insemination is Covered for up to three inseminations. Donor sperm is not Covered. In-vitro, GIFT and ZIFT fertilization are not Covered. Reversal of voluntary sterilization is not Covered. Infertility diagnosis and treatment, including drugs and injections, are not Covered if received from non-Participating Providers/Practitioners.

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 IEM where there are standard methods of treatment, when Medically Necessary and subject to the **Limitations, Exclusions, and Prior Authorization** requirements listed in this Agreement. Medical services provided by licensed Healthcare Professionals, including Practitioners/Providers, dieticians and nutritionists with specific training in managing Members diagnosed with IEM, are Covered.

Covered Services include:

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

For Prescription Drug and special medical food coverage, contact **Express Scripts** at **1-866-217-3774**.

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

Genetic Testing

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

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

Autism Spectrum Disorder

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

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

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

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

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 Provider and administered in the home on an intermittent basis. A visit is one period of home health service of up to **four hours**. This benefit conserves Hospital beds for acutely ill patients and reduces the cost of healthcare.

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

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

- Skilled Nursing Care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);

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

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

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

You may call our Presbyterian Customer Service Center for more information at **(505) 923-5208** or **1-877-752-4164** Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call **TTY 711** or **1-877-298-7407**.

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.

If your In-network Provider recommends you be admitted, your In-network Provider will obtain **Prior Authorization**. If an Out-of-network Provider recommends you be admitted, you must obtain **Prior Authorization.** If **Prior Authorization** is not obtained, the Member will be responsible for a penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

Benefits are available for a non-private room with two or more beds. Private room charges are a covered benefit only when Medically Necessary and when the private room is ordered by the admitting Provider and **Prior Authorization** is obtained from PHP. If the Member requests a private room or the private room is not Medically Necessary, PHP 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, and 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 and are provided in PHP authorized facilities. 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.

Hospitalization for rehabilitation must begin while the Member is covered under this Plan. Inpatient rehabilitation treatment must be Medically Necessary and **not** for personal convenience.
Benefits are **not** available for care that is not provided by a PHP authorized facility. These Inpatient services are not eligible for any additional benefits on an Outpatient basis.

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

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, it is **not** necessary to obtain **Prior Authorization**. However, all Inpatient Behavioral Health services and Alcoholism/Substance Use Disorder services require **Prior Authorization**. You can call the PHP's Behavioral Health Department directly at **(505) 923-5470** or toll-free at **1-800-453-4347** for more information.

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 Use Disorder only.

Outpatient services are available from the following credentialed providers:

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

Mental Health Services

Inpatient Behavioral Health services will be covered when performed by a licensed Provider. Inpatient Behavioral Healthcare requires **Prior Authorization** by PHP's Behavioral Health Department. Please call **(505) 923-5470** or toll-free at **1-800-453-4347.** If **Prior Authorization** is not obtained, the Member will be responsible for a 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 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 that includes various daily and weekly therapies. Two partial Hospitalization days are equivalent to **one day** of Inpatient care. Services require **Prior Authorization** by PHP's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for a penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

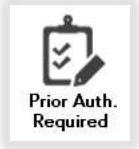
Outpatient, non-Hospital-based short-term evaluative and therapeutic Behavioral Health services will be provided based on medical necessity.

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

Alcohol and Substance Use Disorder Services

All Inpatient Alcoholism and/or Substance Use Disorder services require **Prior Authorization** from PHP's Behavioral Health Department; failure to do so will result in benefits being reduced or denied.



Inpatient treatment in a Hospital or Substance Use Disorder treatment center requires **Prior Authorization** from PHP's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for a penalty for covered facility services, in addition to Copayments, Deductibles, and/or Coinsurance as listed in the *Summary of Benefits.*

Partial Hospitalization can be substituted for Inpatient Alcoholism and/or Substance 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** from PHP's Behavioral Health Department. If **Prior Authorization** is not obtained, the Member will be responsible for a penalty for covered facility services, in addition to Deductibles and/or Coinsurance as listed in the *Summary of Benefits*. Please refer to the *Summary of Benefits* for day limitations and penalty amounts.

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

Intensive Outpatient Alcoholism and/or Substance Use Disorder services are defined as visits lasting up to **9 hours** per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting between 15 and 110 minutes.

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

Practitioner/Provider Services

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

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

Allergy Services

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

Chronic Pain Treatment

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

Contraceptive Devices

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

- Intrauterine devices (IUDs);
- Diaphragms; and
- Other implantable devices.

If you must obtain the IUD, or a diaphragm from a pharmacy, you will have to pay for the item and then file a claim to the PHP. All other contraceptive devices that do not require a prescription are not a benefit. Prescription Drugs are administered by **Express Scripts**. Members can call **Express Scripts** at **1-866-217-3774**.

Injectable Drugs

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

PHP reserves the right to exclude any injectable drug currently being used by a Member that is not specifically listed as covered. Proposed new uses for injectable drugs previously approved by

the FDA will be evaluated on a medication-by-medication basis. Call a Presbyterian Customer Service Center representative if you have any questions about this policy.

Inpatient Provider Visits and Consultations

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

Office Visits

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

- Office Visits provided by a qualified Practitioner/Provider.
- Video visits provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters.
- PHP Video Visits utilize a nationwide network of providers
- Telehealth appointments through video or telephone are with a network provider, including some Presbyterian Medical Group providers. They require most members to pay a normal copay or cost sharing, just like with an in-person visit.
- Online Visits are an online medical interview followed by a response from a Presbyterian Medical Group provider.
- PHP Video Visits provided online between a designated Practitioner/Provider and patient about non-urgent healthcare matters.

Prescription Drugs/Medications

Prescription Drugs are administered by Express Scripts. **Call Express Scripts at 1-866-217-3774**.

Rehabilitation and Therapy

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

Cardiac/Pulmonary Rehabilitation Services

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

Physical, Occupational and Speech Therapy

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

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

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

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 Provider, and the services of the Provider are available at all times by an established agreement. The facility must also comply with the legal requirements that apply to its operation and keep daily medical records on all patients.

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

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

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 Practitioner's/Provider's office is Covered under the medical benefit. The non-specialist Copayment applies. There is no limit to the number of visits that are Covered. Non-Participating Providers/Practitioners are not Covered.
- Group counseling, including classes or a telephone Quit Line, are Covered through an In-network Practitioner/Provider. No Cost Sharing will apply, and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. You may want to utilize these services.
- Pharmacotherapy Benefits are limited to:
    - Prescription Drugs are administered by **Express Scripts**. Call **Express Scripts** at **1-866-217-3774**.
    - Two **90-day** courses of treatment per Calendar Year.
    - Refer to "Covered Medications" in your *Summary of Benefits* for Coinsurance amounts.

For more information, contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call our **TTY** line at **711** or **1-877-298-7407**.

Exclusions: Hypnotherapy - the use of therapeutic techniques or principles in conjunction with hypnosis. Hypnosis is the process by which a trained therapist helps the patient become so relaxed that the Member may be able to accept new ways of thinking or reacting to behaviors which the patient wishes to change.

Surgery

Benefits are available for the following surgical services:

- Necessary anesthesia services by a qualified Provider;
- Sterilization, but not procedures to reverse voluntary sterilization;
- Services of a Provider who actively assists the operating surgeon in the performance of a covered Surgery when the procedure requires an assistant, but not services of a Provider who is on standby, or available should services be needed; and

- Second or third opinion consultants. The second opinion must be received within six months of when the procedure was recommended. The third opinion must be received within six months of the date the second opinion was given. The Provider giving the second or third opinion must not be the Provider who recommends or performs the Surgery and must practice in a different office than the Provider who recommends or performs the Surgery.

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

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

Cataract Surgery

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

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

Cochlear Implants

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

Congenital Anomalies

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

Oral Surgery

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

Outpatient Surgery

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

Reconstructive Surgery

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

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

Mastectomy Services

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

When breast reconstruction is chosen, Covered Services include:

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

Breast Reconstruction Surgery is limited to a surgical procedure or procedures performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts.

Benefits are also available for procedures related to nipple reconstruction following a mastectomy.

The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plan and health insurance issuers that provide coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).

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

NOTE: If you disagree with PHP'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 PHP decision at any time. See **Grievance** Section.

Transplants

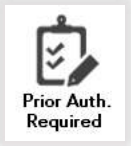
This benefit has one or more exclusions as specified in the **Exclusions** Section.

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

Prescreening at the time of the transplant evaluation and services necessary to complete the evaluation are included in the lifetime benefit maximum as shown in the *Summary of Benefits.*

Organ transplant services include the recipient's medical, surgical and Hospital services; Inpatient Immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants; kidney/pancreas, kidney, liver, lung, pancreas, intestine, or small bowel/liver.

Also covered are islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be Medically Necessary. To be covered, transplant services must also be received within one year of the transplant or retransplant. Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgery."



The treating Provider or Member must obtain **Prior Authorization** from PHP before benefits for any transplant procedure is provided. **Prior Authorization** must be obtained from PHP before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if **Prior Authorization** is not obtained from PHP. A PHP case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation. **In-network Providers request Prior Authorization for you**. **Discuss the need for Prior Authorization with your Provider before obtaining services**.

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

In addition, benefits are available **only** when the transplant is performed at a facility with a transplant program approved by PHP. Call the Presbyterian Customer Service Center, Monday through Friday, between the hours of 7 a.m. and 6 p.m. at **(505) 923-5208** (in Albuquerque), or

toll-free within New Mexico at **1-877-752-4164** for a current list of PHP approved programs. TTY users may call **711** or **1-877-298-7407**.

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

Organ Procurement or Donor Expenses: If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires Surgery to make an organ available for a covered transplant (e.g., kidney or liver), coverage is available for expenses incurred by the donor for travel (if required, covered under the "Transplant" provision, and approved by the PHP case manager), Surgery, organ storage expenses and Inpatient follow-up care only. Donor organ procurement costs are subject to the maximum lifetime payment as shown in the *Summary of Benefits*.

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

Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected. Covered Services related to the transplants are subject to usual cost-sharing features and benefit limitations of this Plan (e.g., Copayments, Deductible/Coinsurance, and out-of-pocket limits; annual home health care maximums).

Reminder: Benefits are available only when the transplant is performed at a facility with a transplant program approved by PHP.

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

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

In addition to you being covered for the charges associated with the item above, such charges will also be considered covered travel expenses for one companion to accompany you. The term

companion includes your spouse, a member of your family, your legal guardian, or any person not related to you but actively involved as your caregiver.

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

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

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

Total benefits for transplant, services, and supplies provided after the transplant are limited to a lifetime maximum payment (excluding drugs for use while at home) per Member, as shown in the *Summary of Benefits*. Benefits applied toward this maximum include payments for Hospitalization and all allowable expenses for one or more transplants and for any subsequent Hospitalizations and medical services related to the transplant.

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

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

Women's Healthcare

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

Maternity and Newborn Care

Benefits include complete prenatal care, pregnancy-related diagnostic tests (including an alpha-fetoprotein IV screening test for women generally between sixteen and twenty weeks of

pregnancy, to screen for certain abnormalities in the fetus), visits to an obstetrician, Certified Nurse-Midwife, or Licensed Midwife, and childbirth in a Hospital or in a licensed Birthing Center staffed by a Certified Nurse-Midwife or Provider. Lay midwife deliveries are **not** a covered benefit. Deliveries by cesarean section, ectopic pregnancies, other pregnancy complications, such as miscarriage, and therapeutic or elective abortions are also covered.

If Maternity benefits change during a pregnancy, the Member receives the benefits in effect on the day the service is received.

Under Family Coverage, a Dependent daughter is eligible for Maternity benefits. Coverage for the baby is available **only** if covered as an eligible Dependent.

Note: To add coverage for your newborn child, you must submit an Application for your child as a Dependent before or within **60 days** of birth. The baby is then covered from the moment of birth. If you have Employee coverage, you must change to Two-Party Coverage; if you have Two-Party Coverage, you must change to Family Coverage; if you already have Family Coverage, you must submit an Application to add your newborn as a Dependent.

However, if you do not apply for your newborn child within **60 days** of birth, you must wait until the next special enrollment period authorized by the City of Rio Rancho to enroll the child.

Once the baby is enrolled, newborn visits in the Hospital by the baby's Provider, circumcision, incubator, and routine Hospital nursery charges are covered. If your baby needs special care, including diagnostic tests and Surgery, the Plan pays benefits for that care too.

A separate Inpatient Copayment for your newborn applies only when the infant's Inpatient stay exceeds the mother's date of discharge. Additional services above and beyond routine newborn care are not subject to an additional Copayment if the infant is discharged on the same day or before the mother is discharged from the Hospital.

If your newborn stays in the Hospital longer than you, the mother, you must notify PHP Health Services by calling **(505) 923-5757** or toll-free **1-888-923-5757** before the mother is discharged from the Hospital to coordinate the baby's care, or benefits may be reduced or denied.

Newborn and Mothers Health Protection Act

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

General Limitations

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

Essential Benefits-Section 1302 (b) of the Affordable Care Act defines essential health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency service; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative service and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

NOTE: If you disagree with PHP'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 PHP decision at any time. See **Grievance** Section.

Benefit Limitations

The benefits below have limits applied.

Acupuncture treatment benefits for covered expenses, in combination with services provided for chiropractic, are limited to a Calendar Year Maximum as outlined in the respective *Summary of Benefits.*

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

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

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

Chiropractic (manipulations) services for covered expenses, in combination with services provided for Acupuncture, are limited to a Calendar Year Maximum as outlined in the respective *Summary of Benefits.*

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

Consumable medical supplies are covered during Hospitalization. They are also covered during an office visit or authorized home health visit. PHP **does not cover** supplies used at other times

by the Member or Member's family. Consumable medical supplies are (1) usually disposable, (2) cannot be used repeatedly by more than one individual, (3) are primarily used for a medical purpose, (4) generally are useful only to a person who is ill or injured and (5) are ordered or prescribed by a licensed Provider.

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

Dental prostheses, craniomandibular joint (CMJ) and temporomandibular joint (TMJ) disorders, pediatric anesthesia and oral Surgery benefits are Covered when Medically Necessary. 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 when **Prior Authorization** is not obtained from PHP (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 exostosis; procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures.
- Duplicate or "spare" appliances.
- Artificial devices and/or bone grafts for denture wear.
- Personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth.

Diabetic supplies and services that require **Prior Authorization**:

- Podiatric appliances;
- Orthopedic appliances

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

Durable Medical Equipment, Orthotic and Prosthetic Devices and external prostheses require **Prior Authorization** when costs exceed $500. In addition, rentals, repairs or replacements require **Prior Authorization**.

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.

Genetic Testing Genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Accordingly, a test to determine whether an individual has BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder if that person has a known family history or classic symptoms of a disorder. Genetic testing is not covered when the test is performed primarily for the medical management of other family members. Additional expenses for banking of genetic material are not covered.

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

Hospice care benefits are limited to patients who are terminally ill, as described in the **Benefits** Section. **Prior Authorization** from the Plan is required.

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.

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

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

Repair or replacement of non-rental Durable Medical Equipment, Orthotic Appliances, and Prosthetic Devices due to normal wear and damage requires **Prior Authorization,** or no benefits are payable under this Plan.

Respite care for a Hospice caretaker will be limited to two respite stays of up to **10 continuous days** per benefit period.

Routine eye screenings are limited to Dependents through age 17.

Routine hearing screenings are limited to Dependents through age 17, except as outlined under the **Benefits** Section.

Transplants and related services and supplies provided after the transplant are limited to a **lifetime maximum benefit payment of $500,000 per Member**. 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 Reasonable and Customary Charges. All payable benefits for transplants accumulate towards the $500,000 lifetime maximum amount payable.

Exclusions

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

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

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

Adoption/Surrogate expenses are not a covered benefit.

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

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

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

Autopsies are not a covered benefit under this Plan.

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

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

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

- Any care which is patient elected and is not considered Medically Necessary;
- Residential Treatment Centers used for the treatment of any condition;
- Care which is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider;
- Workers' Compensation or disability claims are **not covered** as part of treatment;
- Long term Custodial Care of children and adolescents;

- Special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or education and developmental disorders;
- Behavioral problems unless associated with manifest mental illness or other disturbances; and
- Non-national standard therapies, including Experimental as determined by the Behavioral Health professional practice.

Behavioral training is not a covered benefit under this plan.

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

Charges

- In excess of Plan limits.
- In excess of Reasonable and Customary amounts when services are secured from an Out-of-network Provider. This may not apply to Emergency Medical services or Urgent Care services. See the **Benefits** Section for more information.
- Made by a family Member (spouse, parent, grandparent, sibling or child) or someone who lives with you.

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

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

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

Convalescent care or rest cures.

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

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

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

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

Custom-Fabricated ankle-foot orthoses and/or knee-ankle-foot orthoses (AFO and/or KAFO) except for Members up to eight years old when **Prior Authorization** is obtained from PHP.

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

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

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

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

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

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

Duplicate coverage including, but not limited to:

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

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

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

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

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

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

Exercise equipment is not a covered benefit under this Plan.

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

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

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

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

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

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

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

Hearing exams: This Plan does not cover audiometric (hearing) tests unless:

- Required for the diagnosis and/or treatment of an illness or Accidental Injury;
- Covered as a preventive screening service for children through age 17 as part of a routine physical exam; or
- Covered as outlined under “Hearing Aids” above.

Home births

Home health care benefits for care that:

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

Hospice benefits are not available for the following services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical equipment to include, but not be limited to, stethoscopes and blood pressure monitors unless listed as a covered item under this Plan.

Medically unnecessary services: This Plan does not cover services that are not Medically Necessary as defined in the **Benefits** Section unless such services are specifically listed as covered.

Membership fees are not a covered benefit under this Plan.

Meniscal Transplants are not a covered benefit under this Plan.

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

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

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

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

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

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

Obesity treatment is not a covered benefit under this Plan except as listed in the **Benefits** Section.

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

Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom-fitted braces or splints are **not covered**, except for Members with diabetes or other significant neuropathies when **Prior Authorization** is obtained from PHP.

Orthoptics are not a covered benefit under this Plan.

Orthotripsy is not a covered benefit under this Plan.

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

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

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

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

Prescription Drugs: Prescription Drugs are administered by **Express Scripts**. Call Express Scripts at **1-866-217-3774**.

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

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

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

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

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

Rolfing is **not covered** under this Plan.

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

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

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

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

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

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

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

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

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

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

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

Treatment for injuries sustained by a Member in the course of committing a felony if the Member is subsequently convicted of the felony is **not covered**. Claims for any period caused or contributed to by a Participant committing or attempting to commit an assault or felony, participating in an illegal occupation, actively participating in a violent disorder or not, or operating any vehicle while under the influence of any intoxicant. Actively participating does not include being at the scenes of a violent disorder or not while performing his or her official duties.

Unreasonable charges will not be covered by this Plan.

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

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

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

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

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

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

War-related conditions: This Plan does not cover any services required as the result of any act of war, or any illness or Accidental Injury sustained during combat or active military service. Claims which arise out of, or are caused or contributed to by war or an act of war. **War** means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

Weight loss program, obesity treatment, and nutritional counseling expect as outlined in the **Benefits** Section.

Termination

How Coverage Stops

Coverage under this Plan terminates on the last day of the earliest of the following:

- The period in which premiums are paid;
- On the date when eligibility ceases; or
- When the Plan ends

If a Dependent becomes ineligible due to age, coverage ceases at the end of the month following his/her birthday.

If a Dependent loses eligibility due to marriage or divorce, coverage ends the end of month the change has been received by the City of Rio Rancho Employee Benefits Department.

Coverage under this SPD does not end for any Member who is a Hospital Inpatient at the time of the membership termination until benefits applicable to the Admission are exhausted or until the Member is discharged from the Hospital, whichever occurs first.

How to Disenroll Dependents

When you lose a Dependent through marriage, death, divorce, annulment, or legal separation, or a Dependent is ineligible due to age, please submit an Application and any supporting documentation (marriage certificate, final divorce paperwork, proof of other coverage, etc.) to disenroll the Dependent from your coverage. Contact your agency group representative for the necessary forms.

Certificate of Coverage

If your coverage is terminated, the Claim Administrator provides evidence of your prior health coverage by supplying you with a Certificate of Coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for a pre-existing condition or if you want to buy, for you or your family, an individual insurance policy.

Continuation of Coverage Under the Family and Medical Leave Act (FMLA)

If you take a leave of absence that qualifies as a Family and Medical Leave under the Family and Medical Leave Act of 1993 (an FMLA leave), medical coverage for you and your family Members continues as long as you continue paying your portion of the cost of coverage during the FMLA leave. Your agency group representative will advise you of the methods available to continue paying for your coverage. If you elect to discontinue medical coverage during an FMLA leave and subsequently return to work, your coverage will be reinstated with no waiting period or pre-existing condition limitation. For additional information on FMLA leave and the effect on your benefits, please contact your agency group representative.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

City of Rio Rancho supports voluntary military service with the United States armed forces and complies with all laws that protect your rights to benefits during or following a period of military service. If you leave the City of Rio Rancho employment to serve in a branch of the United States armed forces, you may be eligible to apply for reemployment in conformance with the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments thereto. Contact the City of Rio Rancho's Employee Benefits Department to discuss your rights under this law.

Continuation of Coverage Under (COBRA)

This Plan is subject to the provisions for continuation of plan coverage under Federal law (COBRA). The employee and his/her covered Dependents who lose eligibility under this Plan may continue as Group Members for a limited period of time.

On April 7, 1986, a new Federal law was enacted (Public Law 99-272, Title X "COBRA") requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of healthcare coverage (called "COBRA continuation of coverage") at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation of coverage provisions of this law. Both you and your spouse should take the time to read this section carefully.

If you are an employee of the City of Rio Rancho covered by this healthcare plan, you have the right to choose this continuation coverage if you lose your group health coverage due to a reduction in your hours of employment below **30 hours** per week; or change in employment category to Temporary, Occasional/Seasonal or On-call; or the termination of your employment (for reasons other than gross misconduct on your part).

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

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

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

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

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

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

Should one of the above events have occurred, the Plan Administrator will in turn notify you (within **14 days** of receipt of notification) that you have the right to choose continuation of coverage. Under this law, you have at least **60 days** from the date you would lose coverage due to one of these events or the date you receive the notice of your rights to choose continued coverage.

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

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

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

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

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

COBRA and the Family and Medical Leave Act (FMLA)

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

- The date you unequivocally inform the City of Rio Rancho Employee Benefits Department that you are not returning at the end of the leave;
- The date your leave ends, assuming you do not return; or
- The date the FMLA entitlement ends

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

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

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 PHP 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

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 a Presbyterian Customer Service Center representative.

The Member Claim Forms are available from your agency group representative or a Presbyterian Customer Service representative. They can also be printed out from our website at **www.phs.org**. Please mail the claim forms and itemized bills to:

Presbyterian Health Plan, Inc.
Attn: City of Rio Rancho HDHP Claims
P.O. Box 27489
Albuquerque, NM 87125-7489

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

Out-of-Network Service Claims

When you obtain Provider or Outpatient Hospital services Out-of-network, the Provider, the Hospital, or you should file the claims with PHP. If the Provider 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 Provider care, claims should be handled the same way as described in "Out-of-network Claims" above. Members are responsible for ensuring that claims are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States.

Itemized Bills

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

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

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

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

How Payments are Made

Payments to Out-of-network Providers are sent to the Out-of-network Provider when possible. However, PHP 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 PHP. 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 Reasonable and Customary amounts. This may not apply to Emergency Medical Services or Urgent Care Services. See **Benefits** Section for more information. 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 PHP.

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

Overpayments

If payments made by PHP 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 PHP.

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. Any premiums collected from the Member for coverage that is later revoked due to a fraudulent Application will be refunded to the Member by the Plan. If a claim is paid by PHP 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 PHP.

Effects of Other Coverage

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

Coordination of Benefits

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. Under this provision, if a Member is eligible for benefits under any other valid coverage, the combined benefit payments from all coverage 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 a Presbyterian Customer Service Center representative 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 unless a pre-existing condition limitation applies 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:

- No COB Provision. If the other valid coverage does not include a COB provision, that coverage pays first, and this Plan pays secondary benefits.
- Employee/Dependent. If the Member who received care is covered as the employee under one 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:
    - benefits of the plan of an active worker covering the Medicare beneficiary as a Dependent;
    - Medicare;
    - 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 center 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
- Dependent Child/Parents Not Separated or Divorced. If the Member who receives care is a Dependent child, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the other valid coverage does not follow the birthday rule, then the gender rule applies (that is, the male parent's coverage pays first).

- 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:
    - 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.
    - 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.
    - 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.
- Active/Inactive Employee. If the Member who received care is covered as an active employee under one 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 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.
- 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, PHP limits its secondary benefit payment to the difference between the PHP 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 do not meet these obligations and your primary benefits are reduced as a result, PHP limits its secondary benefit payment to the difference between the PHP 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 do not meet these obligations and your primary benefits are reduced as a result, PHP limits its secondary benefit payment to the difference between the PHP Negotiated Fee-for-Service for the service received and the amount that would have been paid if you had met the obligations.

Medicare

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 City of Rio Rancho 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 PHP 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.

Medicaid

Benefits payable on behalf of a Member who is qualified for Medicaid will be paid to the Plan when:

- The Plan has paid or is paying benefits on behalf of the Member under the Group's Medicaid program pursuant to Title XIX of the Federal Social Security Act; and
- The payment for the Services in question has been made by the Plan to the Medicaid Provider.

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, PHP 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 any and 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 PHP's subrogation right. You must notify PHP if you file a claim, consult an attorney, or bring action against a third party. If contacted by PHP, you must provide all requested information. Settlement of a controversy without prior notice to PHP is a breach of this agreement. In the event that you fail to cooperate with PHP or take any action, through agents or otherwise, to interfere with the exercise of a subrogation right of PHP, PHP 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.

Grievance Procedures

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

Many Grievances or problems can be handled informally by calling Presbyterian Health Plan at **(505) 923-5208** or toll-free at **1-877-752-4164**. Hearing-impaired users may call our TTY line at **711** or **1-877-298-7407**, or visit our website at **www.phs.org.** The Managed Health Care Bureau of the New Mexico Insurance Division is also available to assist you with Grievances, questions or Complaints; call **1-888-4ASK-PRC (1-888-427-5772)**.

We (Presbyterian Health Plan) have established written procedures for reviewing and resolving your Grievances and concerns. There are two different procedures, depending on the type of Grievance. Any Member dissatisfied with a decision, action or inaction of ours, including a Termination of Coverage, has the right to request an internal review. You may submit your request verbally or in writing.

Adverse Determination: means a decision made either pre-service or post-service, by Presbyterian that a Healthcare Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, does not meet Presbyterian's requirements for Coverage or Medical Necessity, and the requested HealthCare Service is denied, reduced or terminated.

Adverse Determination Grievance: means an oral or written complaint submitted by or on behalf of a Covered Person regarding an Adverse Determination.

Administrative Grievance: means an oral or written complaint submitted by or on behalf of a Covered Person regarding any aspect of a Health Benefits Plan other than a request for Healthcare Services, including but not limited to:

- Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of Healthcare Services
- Claims payment, handling or reimbursement for Healthcare Services
- Terminations of Coverage

Any Grievance may be submitted orally or in writing. If you make an oral Grievance, the Presbyterian Customer Service Center will assist you to complete the required forms. The Managed Health Care Bureau of Insurance Division is also available to assist you. Please be advised that we shall not take any retaliatory action against you for filing a Complaint.

If your Grievance clearly contains administrative and adverse decision issues, then we will begin separate Grievances for each decision. When processing your Grievance, we will provide you with a detailed explanation of the Grievance procedure. The detailed explanation will tell you how we review and resolve Grievances, provide you with a toll-free telephone number, facsimile number, email address, and mailing address of Presbyterian's Consumer Assistance Office.

You may request a copy and detailed written explanation of the Grievance procedures by calling the Presbyterian Customer Service Center at **(505) 923-5208** or toll-free at **1-877-752-4164**. Hearing-impaired users may call our TTY line at **1-877-298-7407** or **711**.

Members have **180 days** from the date of the initial denial to file an Appeal with us.

Initial Determinations
When you or your treating healthcare professional requests a Healthcare Service, we shall initially determine whether the requested Healthcare Service is a Covered Benefit by your Health Benefits Plan. Before denying a Healthcare Service for lack of Coverage, we will determine that there is no provision under which the requested Healthcare Service could be Covered. If we find that the requested Healthcare Service is not Covered, PHP will not review for Medical Necessity. If PHP finds that the requested Healthcare Service is a Covered benefit, PHP will then determine if it is Medically Necessary. Before we deny a Healthcare Service because of lack of Medical Necessity, our Medical Director will give an opinion as to Medical Necessity by either consulting relevant specialists or applying Uniform Standards that we use.

The initial determination must be completed within **24 hours,** where circumstances require expedited review and **five working days** for all other cases. We may extend the review period for a maximum of **ten working days** for pre-services cases if there is a demonstration of reasonable cause beyond control for the delay, the delay will not result in increased medical risk to you, and if a written progress report and explanation for the delay within the original **five working day** review period is sent to you.

An expedited decision will be granted whenever:

- The life or health of a Covered Person would be jeopardized
- The Covered Person's ability to regain maximum function would be jeopardized
- The Practitioner/Provider reasonably requests an expedited decision
- The medical exigencies of the case require an expedited decision

If our initial review results in the approval of the requested service, then we will notify you and your Practitioner/Provider of the approval by telephone or written correspondence within **two working** days of the date we approved the service.

If our initial review results in the denial, reduction or termination of the requested Healthcare Service, then we will notify you and your doctor of the determination by telephone no later than **24 hours** after making the initial decision. We will also notify you and your doctor of the initial decision in writing within **one working day** of the telephone notice. The written notice will state:

- If the decision is based on lack of Medical Necessity, we will explain why the service is not Medically Necessary. A statement that the Healthcare Service is not medically necessary is not sufficient.

- If the decision is based on lack of Coverage, all benefit plan provisions and materials will be cited completely explaining why the requested service is not a Covered Benefit. A statement that the requested Healthcare Service is not covered by the Health Benefits Plan will not be sufficient.
- How you may request an internal review with us.
- Procedures and provide all the necessary forms you will need to request an internal review.

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

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

Phone: (**505) 923-5208** or toll-free at **1-877-752-4164**
Fax: **(505) 923-6111**
Email: **gappeals@phs.org**

You may also contact the Insurance Division's Managed Health Care Bureau for assistance.

Adverse Determination Grievance Review Procedures
If you are dissatisfied with an Adverse Determination, you have the right to request an internal review by us. Once we receive your request for an internal review, we will date and time stamp your request and send you an acknowledgment letter within one **working day**. Our acknowledgment letter will tell you the name, address, and direct telephone number of the individual handling your request.

Our internal Adverse Determination Appeal Review Procedures require an initial review by one of our Medical Directors and then, if necessary, a second review by a medical panel. If your request was initially denied because of lack of Coverage, our Medical Director will review your Healthcare Benefits Plan booklet to determine if there is any provision under which the requested Healthcare Service could be Covered. If the initial request was based on lack of Medical Necessity, then our Medical Director will give an opinion as to Medical Necessity by either consulting relevant specialists or applying the Uniform Standards that we use. If our decision is to approve the requested service, Presbyterian Health Plan will notify you and your Practitioner/Provider by telephone and written correspondence within **two working days** of the date we approved the service. Both reviews must be completed within **72 hours** when the circumstances require expedited review; or within **30 working days** for all cases in which the request for review is made prior to the service requested; and **60 working days** for all cases that involve post-service reviews if the Grievance contains clearly divisible administrative and adverse decision issues, then the Healthcare Insurer shall initiate separate complaints for each decision.

An expedited review is conducted when it is determined your life or health could be in jeopardy, or your ability to regain maximum function would be jeopardized. In an expedited review, all information will be transmitted between you and us by the most expeditious method available. If an expedited review is conducted during a Hospital stay or course of treatment, the Healthcare Services will be continued without cost (except for applicable Cost Sharing Copayments, Coinsurance and Deductibles) to you until we make a final decision and notify you. We will not conduct an expedited review of an Adverse Determination made after Healthcare Services have been provided to you. Presbyterian will work with you if an extension is needed – **10 working days** for pre-service cases and **20 working days** for post-service cases. If you do not make an immediate decision to pursue the Grievance, or you request additional time to supply supporting documents or information, or postponement, the time frames shall be extended to include the additional time requested by you. We must demonstrate a reasonable cause beyond control when requesting an extension. We will send you a written progress report explaining the reason for the delay. If we fail to comply with the deadline for completion of an internal review, the requested service may be approved unless you agree in writing to an extension.

If our Medical Director decides to uphold the denial, reduction or termination of the requested Healthcare Service, then we will notify you of the Medical Director's decision by telephone and mail and will ask you whether you want a second review by a medical panel that we select. If you indicate that you no longer wish to pursue the Grievance, we will mail to you a written notification of our decision and confirmation of your decision that you do not wish to pursue the matter further within **three working days** of the Medical Director's decision. If we are unable to contact you by telephone within **72 hours** of making the decision to uphold, we will notify you by mail of the decision and will include a self-addressed stamped response form that asks whether you wish to pursue the Grievance further. The form will include a box for checking "yes" and a box for checking "no." If you do not return the response form within **10 working days,** we will again contact you by telephone. If you do not respond to our telephone inquiries or return the response form, we will close the file, including the documented efforts to contact you within **20 working days**. If the review is an expedited review, then we will select a medical panel to further review your request. We will not reasonably deny your request for a postponement of the internal panel review. The time frames for internal panel review shall be extended during the period of any postponement.

If you indicate that you want a second review of your Appeal by a medical panel, then we will notify you of the date, time, and location of the medical panel review and of your rights to participate in the review. No fewer than **three working days** before the internal panel review, we will provide you with a copy of your appeal file. Pertaining to the internal panel review, you have the right to:

- Attend and participate in the internal panel review
- Present your case to the internal panel
- Submit any additional information before and at the internal panel review
- Ask questions of any of the Presbyterian representatives, including the internal panel
- Be assisted or represented by a person of your choice, including legal representation at your expense

- Be advised if we will have legal representation at the hearing
- Hire a specialist to participate in the internal panel hearing at your own expense, but the specialist may not participate in making the decision

We will select one or more Healthcare Professionals who have not been previously involved in your request to serve on the internal panel. At least one Healthcare Professional selected will practice in a specialty that would typically manage the case related to your Grievance. Internal panel review Members will be present physically or by video or telephone conferencing to hear your Grievance. A panel Member who is not present to hear the Grievance either physically or by video or telephone conference shall not participate in the decision.

The internal review panel will review your Health Benefits Plan booklet to see if there is any provision under which the requested Healthcare Service could be Covered. The internal review panel will give an opinion as to Medical Necessity by either consulting relevant specialists or applying Uniform Standards that we use.

No fewer than **three working days** prior to the internal panel review, we will provide you with copies of the following:

- Pertinent medical records
- Your Practitioner/Provider's recommendation
- Your Health Benefits Plan booklet
- All of our decision letters
- Any Uniform Standards that we used
- Any reports received from any medical consultants that we retained
- All other evidence or documentation used in your review

For an expedited internal review, all information will be provided to you by the most expeditious method available. If an expedited review is conducted during a Hospital stay or course of treatment, we will continue the Healthcare Service (applicable Cost Sharing Copayments, Coinsurance and Deductibles apply) until we make a final decision.

Once the internal panel has made their decision, you will be notified within **24 hours** by telephone and in writing within **one working day** of the telephone notice. The written notice will include:

- The names, titles, and credentials of the internal review panel Members.
- A statement of the internal panel's understanding of the Grievance and all pertinent facts.
- The rationale for the internal review panel's decision including the following:
    - Identification of those provisions of your Health Benefits Plan booklet that we believe is relevant to the issue in the case under review and explain why each such provision did or did not support the panel's decision regarding coverage of the requested Healthcare Service.

    - Citation to any Uniform Standards relevant to your medical condition and whether such standards support or do not support the panel's decision regarding the Medical Necessity of the requested service.
- Reference Uniform Standards relevant to the decision.
- Reference any other evidence or documentation used to make the decision.
- Your right to request an external review by the Superintendent of Insurance which will include the address and telephone number of the Managed Health Care Bureau of the Insurance Division and a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate the external review process.

External Review by the Superintendent of Insurance
If you are dissatisfied with the results of our review of an Adverse Determination, you may request an external review by the Superintendent by filing a written request within **120 calendar days** from the date you receive our decision. You may also file any other supporting documents or information to the Superintendent for review. If you wish to supply supporting documentation or information subsequent to the filing for an external review, the time frames for external review shall be extended up to **90 days** from the receipt of the complaint by the Superintendent or until you submit all supporting documents, whichever occurs first. You may request the Superintendent extend your request if good cause is shown. 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 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269.
- Email to the Superintendent of Insurance, Attention: Managed Health Care Bureau at **mhcb.grievances@state.nm.us**.
- 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**.
- You or your Practitioner/Provider may request an expedited review by calling the Managed Health Care Bureau at **(505) 827-3928** or **1-877-673-1732**.

You will need to provide a copy of our decision, a fully executed release form authorizing the Superintendent to obtain any necessary medical records from us or other Healthcare Service Practitioner/Provider, and any other supporting documentation. If the Grievance involves an Experimental or Investigational Treatment Adverse Determination, provide a copy of your Practitioner's/Provider's certification and recommendation. You may contact the Managed Health Care Bureau to assist you in this process. The Superintendent may require you to exhaust any of our internal Grievance procedures before accepting a Grievance for external review.

Once your request for an external review is received, the Superintendent will send an acknowledgment that your request has been received. The Superintendent will also send us a copy of your external review request. Upon receipt of this request, we, within **five working days**

for standard review or the time limit set by the Superintendent for expedited review, will provide the Superintendent:

- Your *Summary of Benefits*
- Your complete Health Benefits Plan booklet
- All pertinent medical records, internal review decisions and rationales, consulting reports, and any documents and information submitted by you and us.
- Any Uniform Standards that we use
- All evidence or documentation used in your internal review

If we fail to comply with these Superintendent's requirements, the Superintendent may reverse our decision. The Superintendent may waive these requirements if the medical exigencies of the case deem it necessary.

The Superintendent will conduct either a standard or an expedited external review. The Superintendent will complete an expedited external review of your case no later than **72 hours** of receipt of the external review request. The insurance division staff will complete the initial review of your case within **10 working days** from receipt of your request for an external review. If you are granted an external review hearing, the Superintendent will complete the external review within **30 working days** from receipt of the complete request for external review. The Superintendent may extend the external review period for up to an additional **10 working days** when deemed necessary.

Upon receipt of your request for external review, the insurance division staff will review your request to determine whether:

- You have provided the necessary documents.
- You are or were a Covered Person under our Health Benefits Plan at the time the service was requested or provided.
- You have exhausted all of our internal review procedures.
- The requested service is a Covered Benefit under your Health Benefit Plan booklet.

The Division of Insurance staff shall attempt to informally resolve the Grievance in accordance with the procedures set forth in the New Mexico Administrative Code. If your external review request pertains to an Experimental or Investigational treatment, the insurance division staff will also consider whether the requested service is a Covered Benefit, is not listed as an excluded benefit under your Plan and whether your doctor has certified that standard Healthcare Services have not been effective or are not medically appropriate for you. The insurance division staff will also consider whether there is no standard Healthcare Service that we Cover that is as beneficial as or more beneficial than the requested service.

If your request for external review is incomplete, the insurance division staff will notify you and require you submit the additional information. If your request for an external review does not meet criteria, the Superintendent will notify you and us that your request will be denied. You have the right to request a hearing within **33 days** from the date the notice was mailed to you. If

the Superintendent determines your request for an external review is complete and meets the criteria, the Superintendent will notify you and us that your request meets criteria and an informal hearing will be scheduled. The notice of hearing will be mailed to you no later than **eight working days** prior to the hearing date. The notice will tell you the date, time, place of the hearing, matters to be considered and will advise you and us of your rights. The Superintendent will not unreasonably deny your request or our request for a postponement of the hearing.

The Superintendent may designate a Hearing Officer who will be an attorney licensed to practice in New Mexico. A 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. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense. The Superintendent may also designate two independent Co-hearing Officers who will be licensed Healthcare Professionals. At least one of them will practice in a specialty that would typically manage the case related to your Grievance. Each Hearing Officer will disclose any potential conflicts of interest to the Superintendent. Any potential conflicts of interest can include personal or professional relationships to either you or us. The Superintendent will determine reasonable compensation for the appointed Hearing Officers and will annually publish a schedule of Hearing Officer's compensation in a bulletin. The Superintendent or attorney Hearing Officer may require additional information, may exclude any irrelevant evidence, may adjourn or proceed with the hearing if you or we fail to attend the hearing. Staff may attend the hearing, ask questions, and request evidence from the parties, but will not be present during deliberations between the Superintendent, his designated Hearing Officer, and any Co-hearing Officers. All testimony at the hearing will be taken under oath. The Superintendent or Hearing Officers may call and examine you, our designees, and other witnesses. The hearing will be recorded and you and we have the right to attend the hearing. You have a right to designate a person to attend on your behalf, be assisted or represented by an attorney and call, examine and cross-examine witnesses. You and we will each enter into record that the Hearing Officers will be released from civil liability for all communications, finding, opinions, and conclusions made during the external review process. At the close of the external hearing the Hearing Officers will review and consider your entire record and submit their decision to the Superintendent who will then render a decision in your case to include any further Grievance rights. If the decision requires action on our part, the order will state the time frame for compliance. Once your external review is complete, the Hearing Officers will complete a compensation form indicating the amount of time spent participating in your external review. The completed forms will be submitted to the Superintendent and will be forwarded to us. We will compensate the Hearing Officers for time served within **30 days** of receipt.

The Superintendent's order will be binding to both you and us and will state that both you and PHP have the right to judicial review pursuant to New Mexico Statutes as state and federal law may provide other remedies. You or we cannot file a subsequent request for external review of the same Adverse Determination that was the subject of the Superintendent's order.

Administrative Grievance Procedures
If you are dissatisfied with a decision, action or inaction of ours regarding a matter that does not involve the denial, reduction or termination of a requested Healthcare Service, then you have the right to request, orally or in writing, that we internally review the matter. Once we receive your request for an internal review, we will date and time stamp your request and send you an acknowledgment letter within **three working days.** Our acknowledgment letter will tell you the name, address, and direct telephone number of the individual handling your request. Your request will be conducted by our representative, who will allow you to present any information related to your case and who will take corrective action if necessary. We will review the Grievance and provide you with a written decision within **15 working days** from receipt of the Grievance. We will notify you if an extension is necessary. An extension may be granted when there is a delay in obtaining the documents or records necessary to appropriately review your Grievance. We will notify you in writing of the reasons for the extension and the expected date of resolution. Your written decision will include:

- The name, title, and qualifications of the person conducting the initial review.
- A statement of the reviewer's understanding of the Grievance and all pertinent facts.
- The rationale for the decision.
- Every relevant provision of your Health Benefits Plan booklet.
- Reference Uniform Standards relevant to the decision.
- Reference any other evidence or documentation used to make the decision.
- Your right to request a reconsideration within **20 working days,** including all necessary forms.

If you are dissatisfied with this decision, you may file a written request for our reconsideration. We will appoint a reconsideration committee, consisting of one or more employees of the Plan who were not involved in the initial decision, to review the Grievance and will schedule a hearing. The hearing shall be held during regular business hours at a location reasonably accessible to the Grievant, and we shall offer the Grievant the opportunity to communicate with the committee, at our expense, by conference call, video conferencing, or other appropriate technology. We shall not unreasonably deny a request for postponement of the hearing made by a Grievant. We will notify you of the date, time and location of the hearing and your rights in this process within **10 working days** after your hearing request is received. No fewer than **three working days** prior to your hearing, we will send you all the documents and information the committee will be reviewing. The reconsideration committee hearing will be held within **15 working days** after your hearing request is received. We will mail you a written decision within **seven working days** after the hearing.

Pertaining to the reconsideration committee review, you have the right to:

- Attend and participate in the reconsideration committee review
- Present your case to the internal panel
- Submit any additional information before and at the reconsideration committee review
- Ask questions of any of our representatives, including the internal panel
- Be advised if we will have legal representation at the hearing

- Be assisted or represented at your expense by a person of your choice

You will be mailed a written decision within **seven working days** after the reconsideration committee hearing. Your written decision will include:

- The names, titles and qualifications of the reconsideration committee panel.
- The committee's statement of the issues involved in your Administrative Grievance.
- An explanation of the rationale of the committee's decision.
- References to the evidence or documentation used to make the decision.
- A statement that the initial decision will be binding unless you submit a request for an external review by the Superintendent within **20 working days** of receipt of the reconsideration decision.
- Instructions, procedures and forms on how to submit the Administrative Grievance to the Superintendent including address and toll-free telephone number.

External Review by the Superintendent of Insurance
If you are dissatisfied with the results of the review by our reconsideration committee, you may request an external review by the Superintendent by filing a written request within **20 working days** from the date you receive our decision. You may also file any other supporting documents or information to the Superintendent for review. If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the time frames for external review shall be extended up to **90 days** from receipt of the complaint form by the Superintendent or until you submit all supporting documents, whichever comes first. You may file your request for external review on the forms we provided by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau—External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269.
- Email to the Superintendent of Insurance, Attention: Managed Health Care Bureau at **mhcb.grievances@state.nm.us**.
- 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**.

The Superintendent may require you to exhaust any of our internal Grievance procedures before accepting a Grievance for external review.

Once your request for an external review is received, the Superintendent will send an acknowledgment that your request has been received. The Superintendent will also send us a copy of your external review request. Upon receipt of this request, we, within **five working days** for standard review or the time limit set by the Superintendent for expedited review, will provide the Superintendent:

- Your *Summary of Benefits.*

- Your complete Health Benefits Plan booklet.
- All pertinent medical records, internal review decisions and rationales, consulting reports, and any documents and information submitted by you and by us.
- Any Uniform Standards that we use.
- All evidence or documentation used in your internal review.

The Superintendent will review the documents submitted by you and by us and may conduct an investigation or inquiry with the Grievant. The Superintendent will issue a written decision to you within **20 working days** of receipt of the external review request.

Retaliatory Action
In accordance with the federal Patient Protection and Affordable Care Act, and the New Mexico Administrative Code's Grievance Procedures Rule, we cannot take retaliatory action against you for filing a Grievance under this Health Benefits Plan.

Confidentiality of a Covered Person
In accordance with the New Mexico Administrative Grievance Procedure Rule, Healthcare Insurers, the Superintendent, independent Co-hearing Officers, and all others who acquire access to identifiable medical records and information of Covered Persons when reviewing Grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

Records

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

Creation of Non-Medical Records

We shall keep your records related to personal identification information, which does not specifically relate to your medical diagnosis or treatment. The individual member and/or Group shall forward information periodically as may be required by PHP in connection with the administration of this Agreement.

Accuracy of Information

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

Consent for Use and Disclosure of Medical Records

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

Professional Review

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

Confidentiality of Protected Health Information/Medical Records

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

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

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

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

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

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

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

- Psychotherapy notes
- Information gathered in reasonable expectation of, or for use in, a civil, criminal, or Administrative action or proceeding
- PHI maintained by us that is subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 U.S.C. 263a, to the extent the provision of access to you would be prohibited by law; or exempt from the Clinical Laboratory Improvements Amendments of 1988 (CLIA), pursuant to 42 CFR 493.3(a)(2)

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

Presbyterian Health Plan
Attn: Director, Presbyterian Customer Service Center
P.O. Box 27489

Albuquerque, NM 87125-7489

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

Routine Uses and Disclosures of PHI

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

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

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

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

Consents/Authorizations

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

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

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

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

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

To request an Authorization Form, please contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407,** or visit our website at **www.phs.org**. Authorization Forms will be kept in your medical record or enrollment file.

Members Who Are Unable to Give Consent/Authorization
Sometimes courts or doctors decide that certain people are unable to understand enough to make decisions for themselves. Usually, a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian) can exercise the health information rights described herein for the child or other person, but not always. Unless otherwise required or permitted by law, when we need an Authorization Form signed for a person who can't make healthcare decisions for themselves, we will have it signed by their legal guardian/Personal Representative.

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

Process for Members to Request an Accounting of Disclosures of PHI
You (or your legal guardian/Personal Representative) may request an accounting of PHI disclosures by submitting a request to our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407**, or visit our website at **www.phs.org**. With some exceptions, as described in the Notice of Privacy Practices issued by us in a separate document, the accounting will show when we disclosed PHI about you to others without authorization from you.

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

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

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

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

Internal Protection of Oral, Written and Electronic PHI Across PIC
To ensure internal protection of oral, written, and electronic PHI across our organization, the following rules are strictly adhered to:

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

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

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

- Website traffic statistics, including:
  - Where visitor traffic comes from
  - How traffic flows within the website
  - Browser type
  - We monitor traffic statistics to help us improve the website and find out what visitors find interesting and useful
- Personal information that you provide to us (such as your name, address, billing information, Health Benefit Plan enrollment status, etc.) if you fill out a form on our website.
  - We use your personal information to reply to your concerns. We save this information as needed to keep responsible records and handle inquiries.
  - We do not sell, trade, or rent personal information provided by visitors to our website to other persons, companies or partners.

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

If you have any questions regarding your PHI or would like to access your health records, you can contact our Presbyterian Customer Service Center Monday through Friday from 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY 711** or **1-877-298-7407,** or visit our website at **www.phs.org**.

Eligibility, Enrollment, Effective Dates

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

Who is Eligible

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

Eligible Subscribers

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

- Meet City of Rio Rancho eligibility requirements; and
- Be a permanent employee of City of Rio Rancho, currently working a minimum of **20 hours** per week; and
- Be eligible to participate in medical and Hospital benefits arranged by City of Rio Rancho; and
- An employee cannot carry duplicate benefit coverage; if both you and your spouse work for the same employer, you may not enroll each other as an eligible spouse on any plan described in this booklet, nor may you both cover your children. Double coverage outside the City of Rio Rancho Employer Sponsored Group Benefits Plan is allowed; and
- Meet any other eligibility criteria as specified by City of Rio Rancho

Eligible Dependents

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

- Be your legally married spouse, as defined by state law and physically live in PHP's Service Area as defined by PHP; or
- Be your Domestic Partner who is not employed by the City of Rio Rancho; Domestic Partners are defined as couples who are in an exclusive and committed relationship for mutual benefit, similar to that of marriage. Domestic Partners must share a common, primary residence for 12 or more consecutive months and must be jointly responsible for each other's common welfare, as well as shared financial obligations. Domestic Partners must be at least 18 years of age and may not be married; nor can they be a member of another domestic partnership. Domestic partners are also forbidden from being blood relations to a degree of closeness that would prevent them from being married in their state of residence. A signed Affidavit of Domestic Partnership must be provided to the City of Rio Rancho Human Resources in order for a partner to be added as a Dependent;

- Be your Dependent child who is:
    - Under 26 years of age;
    - Your own or legally adopted child or a child for whom you are legal guardian or have legal custody as defined by state law;
    - In your Custodial Care as appointed by court order;
    - Note: Only the eligible court-ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the first of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent will be the first of the month following receipt of the request by the employer. The employee of the Dependent must meet any applicable waiting periods imposed by the Group and only the eligible, court-ordered Dependent will be allowed to enroll. The City of Rio Rancho's waiting period requirement for all employees is the first of the month following **30 days** of employment.
    - Children of Domestic Partners. Benefits are also available to domestic partner's children provided that the child is primarily dependent upon the employee or domestic partner for support and one or both of the domestic partners is the biological child of the parent, adoptive parents of the child, or the child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or court order; with the exclusion of foster children.
    - Your stepchild (foster children are not eligible);
    - A child for which a court or qualified administrative order is imposed or a child of non-custodial parent(s).
    - Who depends on you for support. Dependent children who are eligible to be enrolled under this item 2. Subsection b. are not required to live in the Service Area. City of Rio Rancho may require proof of eligibility. Enrollment of a Dependent child under this Contract shall terminate upon attainment of the child's 26th birthday, except as provided in item 2. Subsection d. below or earlier marriage; or
    - Be your or your spouse's Dependent child, under 26 years of age, for whom you are required by court order to provide healthcare Coverage. Dependent children who are eligible to be enrolled under this item 2. Subsection c. are not required to live in the Service Area, and Coverage is provided as described in Court-Ordered Coverage for Dependent Children. Enrollment of a Dependent child under this Contract shall terminate at the end of the month upon attainment of the child's 26th birthday.
    - The attainment of the limiting age referenced in item 2. Subsections b. and c., above, shall not terminate the Coverage under this Agreement of a Dependent unmarried child who is totally and permanently disabled. The Dependent must be incapable of self-sustaining employment by reason of mental disability or physical handicap and chiefly dependent upon the Subscriber for support and maintenance. For Coverage to be continued for such Dependent child, you must furnish proof of such disability, incapacity and dependence to City of Rio Rancho

within **30 days** of the Dependent child's attainment of age 26, and each birthday thereafter if requested by City of Rio Rancho.

Enrollment and Effective Dates

Eligible Subscribers and Dependents may enroll at the following times and in the following manner:

- Subscribers, together with eligible Dependents, may enroll by submitting completed application forms to City of Rio Rancho. The signed and completed application form must be received by City of Rio Rancho within **30 days** of the effective date.
- Subscribers and eligible Dependents may begin receiving services for Covered Benefits at 12:01 a.m. on the first day of the month following the date of hire if the names of the Subscribers and eligible Dependents have been received in writing by City of Rio Rancho. (If the date of hire is on the first day of the month, then coverage begins at 12:01 a.m. on that day.) Please contact City of Rio Rancho Human Resources for details.
- Newly hired employees of City of Rio Rancho must enroll within **30 days** after becoming eligible. The effective time and date of Coverage will be 12:01 a.m. on the first of the month following completion of City of Rio Rancho's eligibility requirements. If enrollment is not accomplished within the **30-day** period, the next earliest time the eligible Subscriber and eligible Dependents may enroll is the next occurring Annual Enrollment Period except as specifically described below:
    - A child for whom a Subscriber becomes a legal guardian pursuant to court order is eligible to be enrolled as a Dependent for the duration of the guardianship unless otherwise ineligible for Coverage. Such child must be enrolled within **30 days** of the date of the court order granting guardianship. The Dependent will become a Member on the first day of the month following the date the order is filed with the clerk of the court.
    - A child for whom a Subscriber has been ordered by a court of law/qualified administrative order to provide healthcare Coverage is eligible to be enrolled as a Dependent provided that the Subscriber has met City of Rio Rancho's waiting period requirements and the request for enrollment is made within **30 days** from the date on which City of Rio Rancho receives the court/qualified administrative order. The City of Rio Rancho's waiting period requirement for all employees is the first of the month following **30 days** of employment. The Dependent will become a Member on the day stipulated by the court order.
- An eligible person may enroll as a Subscriber or Dependent after the initial eligibility period if the person loses Coverage under all of the following circumstances:
    - The person was Covered under a Group health plan or had individual health insurance Coverage at the time the person was initially eligible to enroll; and
    - The employee stated in writing if requested by City of Rio Rancho at the time the employee was initially eligible to enroll, that he and/or his Dependents were not enrolling because of such other Coverage; and
    - The person's Coverage under the other plan or insurance:

- Was under a COBRA continuation provision, and the Coverage under that provision was exhausted (and not voluntarily terminated);
- Was not under a COBRA continuation period, and either the Coverage was terminated as a result of loss of eligibility or employer contributions toward the Coverage were terminated; and
- Application was made within **30 days** of the date Coverage under COBRA was exhausted, or the date the Coverage (or the employer's contribution toward Coverage) was terminated

- Upon expiration of any applicable **30-day** period for eligibility, enrollment in this Plan can occur only during a subsequent Annual Enrollment Period.

Special Enrollment for Active Employees and Their Dependents

An employee who failed to enroll in this Plan during a previous enrollment period but who would otherwise be eligible for Coverage may enroll in this Plan due to a Special Enrollment event. Application must be made within **30 days** of acquiring a new Dependent through marriage, birth, adoption or placement for adoption or as specified by City of Rio Rancho. Special Enrollment applies to the Subscriber, spouse and "Eligible Dependents," which include the new Dependents acquired because of the marriage or newborn/adopted children who triggered the event, but not other siblings.

- Effective date of enrollment:
  - In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan, provided it is received within **30 days** of the date of marriage.
  - In the case of a Dependent's birth, the date of such birth and;
  - In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.
- CHIPRA (in accordance with provisions as currently may be defined under Federal law).
  - An employee, who chose not to enroll in this Plan for self and/or Dependent(s) during a previous enrollment period because they were Covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, may request coverage for self and/or any affected eligible Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of the date Medicaid or CHIP coverage terminated.
  - An employee, who chose not to enroll in this Plan for self and/or Dependent(s) during a previous enrollment period and has become eligible for group health premium assistance under State Medicaid or State CHIP, may request coverage for self and/or eligible Dependent(s) if the Dependent is eligible and was not enrolled within **60 days** of becoming eligible.
  - If you apply within **60 days** of the date Medicaid or CHIP coverage is terminated, or within **60 days** of the date the employee is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

Special Enrollment - Change in Family Status

Notwithstanding the provisions specified in Special **Enrollment** of this Section, Subscribers may make certain changes to their benefit elections within **30 days** or, as specified by City of Rio Rancho, of a change in family/employment status. Evidence of a change in family/employment status must be provided to City of Rio Rancho in order to change a Subscriber's benefit elections. Any change in Coverage will become effective on the date of the event of the status change provided the completed request for enrollment is received by the plan within **30 days.** Termination of a Dependent is not a qualifying event for the Subscriber to change benefit plans. The following family/employment status changes are recognized by City of Rio Rancho, as:

- Marriage
    - A Subscriber's newly acquired spouse (and any child of the spouse eligible for Coverage under item A. of this Section) is eligible to be enrolled as a Dependent. Such newly acquired spouse must be enrolled within **30 days** from the date of marriage. Coverage will become effective on the date of marriage.
- Divorce or legal separation;
- Birth or adoption of a child:
    - Newborns of a Subscriber or Subscriber's spouse will be Covered from the moment of birth when enrolled if the signed and completed Enrollment Application form must be submitted to and received by City of Rio Rancho within **30 days** from the date of birth. Otherwise, the newborn cannot be enrolled for Coverage until the next following Annual Enrollment Period. Please refer to the **Benefits** Section, Women's Healthcare, **Prior Authorization** Section, and the **Limitations** and **Exclusions** Section to fully understand the benefits and requirements for Maternity and newborn Coverage.
    - A child for whom the Subscriber has commenced adoption proceedings is eligible to be enrolled as a Dependent. The child will be Covered from the date of placement for the purpose of adoption if the child is enrolled and any applicable Prepayment made within **30 days** of the date of placement. The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Such child shall continue to be eligible for Coverage unless placement is disrupted prior to legal adoption. Placement terminates or is disrupted when the legal obligation terminates.
    - Death of a spouse or Dependent child.
- A change in the Subscriber's spouse's employment (loss of job, or a new job that provides Dependent care assistance or other healthcare Coverage, however, annual enrollment for a spouse's plan is not a family status change);
- A change in legal responsibility for a child;
- The 26th birthday of a Dependent child (coverage will term at the end of the birthday month);
- Marriage of a Dependent child;

- Court order/qualified administrative order to provide health insurance for an eligible Dependent.

Note: Only the eligible court-ordered Dependent will be allowed to enroll. The eligible Dependent will become effective on the date in accordance with the court order. If the court order does not stipulate an effective date, the Dependent will become effective the first of the month following the date the court order was filed with the court. In a case where the employee was not previously compliant to the order, the effective date for the Dependent will be the first of the month following receipt of the request by the employer. The employee of the Dependent must meet any applicable waiting periods imposed by the City of Rio Rancho, and only the eligible, court-ordered Dependent will be allowed to enroll. The City of Rio Rancho's waiting period requirement for all employees is the first of the month following **30 days** of employment. The Subscriber is not eligible to enroll until the next annual enrollment period.

- Disqualification or requalification of a Dependent;
- Qualification or disqualification of a domestic partner;
- Unpaid leave of absence for either the Subscriber or spouse due to a serious health condition;
- Bankruptcy;
- Change in employment status (regular part-time to regular full-time or vice versa);
- Significant change in the cost of a spouse's current plan (50% or greater); and
- An employment transfer that results in a change of residence.

Rescission

Rescission is a cancellation or discontinuance of coverage that has a retroactive effect.

PHP cannot rescind coverage with respect to a Member once the enrollee is Covered under this Plan (Plan B) unless the enrollee performs an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. PHP must provide at least **30 days** advance written notice to each participant who will be affected before coverage can be rescinded.

Glossary of Terms

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

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 use 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.

Administrative Grievance means an oral or written Complaint submitted by or on behalf of a Grievant regarding any aspect of a Health Benefits Plan other than a request for Healthcare Services, including but not limited to:

- Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of Healthcare Services
- Claims payment, handling or reimbursement for Healthcare Services
- Terminations of Coverage

Administrative Services Agreement (ASA) means the administrative agreement between us and the Group.

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

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any

Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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

Agreement means this Summary Plan Description, including supplements, Endorsements or riders, if any.

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

Ambulance Service means a duly licensed transportation service capable of providing Medically Necessary life support care in the event of a life-threatening emergency situation.

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

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

Annual Group Enrollment Period means a period of at least **10 working days** prior to the expiration of each Contract Year mutually agreed to by our company and the Group, during which eligible Subscribers are given the opportunity to enroll themselves and their eligible Dependents under the Agreement without providing satisfactory evidence of good health.

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

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

Application means the forms, including the Employee Action Form and required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for our Coverage.

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

Authorized means **Prior Authorization** was obtained (when required) prior to obtaining Healthcare Services both In-network and Out-of-network.

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

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.

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.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.

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

Certification means a decision by a Healthcare Insurer that a Healthcare Service requested by a Practitioner/Provider or Grievant 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 **Authorized**.

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.

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

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 (DSM-5-5- The Diagnostic & Statistical Manual of Mental Disorders Fourth Edition Copyright 1994).

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

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**.

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

Continuous Quality Improvement means an ongoing and systematic effort to measure, evaluate and improve our processes in order to continually improve the quality of Healthcare Services provided to our Members.

Contract means the Application submitted as the basis for issuance of this Summary Plan Description (Summary). This Summary including the *Summary of Benefits and Coverage*, any supplements, Endorsements or riders, the Application, medical questionnaire (if applicable), the issued Identification Card, and the applicable Group Letter of Agreement or non-Group Membership Letter of Agreement constitute the entire Contract.

Contract Year means the period, or other length of time covered by the Contract, that we and the Group mutually agree to, as specified in the Administrative Services Agreement (ASA).

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

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

Cost Sharing means any contribution Members make towards the cost of their Covered Healthcare Services as defined in their health insurance Agreement. This includes Deductibles, Coinsurance and Copayments.

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

Covered Benefits means benefits payable extended under this Agreement for Covered Health Services provided by Healthcare Professionals subject to the terms, conditions, **limitations and exclusions** of this Contract.

Covered Person means a policy holder, Subscriber, Enrollee, Member or other individual entitled to receive Healthcare Benefits provided by a Health Benefits Plan, and includes Medicaid recipients enrolled in a Healthcare Insurer's Medicaid plan and individuals whose health insurance Coverage is provided by an entity that purchases or is authorized to purchase healthcare benefits pursuant to the New Mexico Health Care Purchasing Act.

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

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 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 is part of the contribution that Members make toward the cost of their healthcare, also known as Cost Sharing. It means the amount the Member is required to pay each Contract Year, directly to the Practitioner/Provider in connection with Covered Healthcare Services before Presbyterian Insurance Company begins to pay Covered Benefits. The Deductible may not apply to all Healthcare Services.

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

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 Provider 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 Health Plan eligibility criteria for healthcare practitioners who provide primary care; and 3) agrees to participate and to comply with Presbyterian Health Plan’s care coordination and referral policies.

Domestic Partner means two unmarried individuals who live together in a long-term relationship of indefinite duration. There must be an exclusive, mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other’s welfare and share financial obligations.

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 Healthcare Services means healthcare evaluations, procedures, treatments, or services delivered to a Member after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Reasonable/Prudent Layperson, to result in:

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

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
- Disfigurement to the person

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

Endorsement means a provision added to the Summary Plan Description (SPD) that changes its original intent.

Enrollee means anyone who is entitled to receive Healthcare Benefits that we provide. Refer to **Member** in this Glossary.

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

- A technology must have final approval from the appropriate regulatory government bodies;

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

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 Coverage means coverage for the employee, the employee's spouse, and/or the employee's Dependent children.

FDA means the United States Food and Drug Administration.

Formulary means a list of drugs approved for Coverage and the tier level at which each is Covered under this Agreement. Our Pharmacy and Therapeutics Committee continually updates this listing. A copy of this listing is available on our website at **www.phs.org** or by calling our Presbyterian's Customer Service Center Monday through Friday 7 a.m. to 6 p.m. at **(505) 923-5208** or **1-877-752-4164**. Hearing-impaired users may call **TTY** Line at **711** or **1-877-298-7407**.

Freestanding Dialysis Facility means a Provider primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home basis.

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 Health Care 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 Administrative Services Agreement (ASA).

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 health plan, or a policy, Contract, certificate or Agreement offered or issued by a Healthcare Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Healthcare Services. This includes a traditional fee-for-service Health Benefits Plan.

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

Healthcare Services means Services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the Health Benefits Plan, physical and mental health Services, including community-based mental health Services, and Services for developmental disability or developmental delay.

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.

High Deductible Health Plan means the Plan option providing reimbursement for Total Allowable Charges only, subject to the Deductible, Out-of-pocket Maximum and Coinsurances.

Home Health Agency means an appropriately licensed Provider that both:

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

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

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

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 Clinical Laboratory means a laboratory that performs clinical procedures under the supervision of a Provider and that is not affiliated or associated with a Hospital, Provider, or Other Provider.

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

In-network Provider means Providers, Hospitals, and other Healthcare Professionals, facilities, and suppliers that have a contract with Presbyterian Health Plan as In-network Providers.

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.

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

Licensed Lay Midwife means a person licensed by the state in which Services are rendered to provide Healthcare Services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

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

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.

Maintenance Therapy means treatment that does not significantly enhance or increase the patient's function or productivity

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

Managed Care means a system or technique(s) generally used by Healthcare Insurers 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 Services by a case manager.
- Insurer 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 Healthcare Plan.

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

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

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

Medical Care means professional Services administered by a Provider or another professional Provider for the treatment of an illness or Accidental Injury.

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

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

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

National Healthcare 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 **Authorization** by the facility.

Obstetrician/Gynecologist means a Practitioner/Provider who is board eligible or board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

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

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 who 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.

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

- An institution or entity only listed as:
    - Ambulance Provider
    - Ambulatory Surgical Facility
    - Birthing Center
    - Durable Medical Equipment Supplier
    - Freestanding Dialysis Facility
    - Home Health Agency

    - Hospice Agency
    - Independent Clinical Laboratory
    - Pharmacy
    - Rehabilitation Hospital
    - Urgent Care Facility
- A person or practitioner only listed as:
    - Certified Nurse Midwife
    - Certified Registered Nurse Anesthetist
    - Chiropractor
    - Dentist
    - Licensed Acupuncturist
    - Licensed Practical Nurse
    - Occupational Therapist
    - Physical Therapist
    - Podiatrist
    - Licensed Lay Midwife
    - Registered Nurse
    - Respiratory Therapist
    - Speech Therapist

Out-of-network 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 a specified dollar amount of Covered Services received in a Calendar Year that is the Member's responsibility, which is determined by the benefit level for the Services received. It does not include expenses in excess of negotiated fees, Reasonable and Customary Charges, non-covered expenses, and specifically excluded expenses and Services.

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

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

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Healthcare and Education Reconciliation Act of 2010 (Public Law 111-152).

Patient Protection and Affordable Care Act

In the event of a conflict between the provisions of your health plan and the provisions of the Act, the provisions that provide the better benefit shall apply.

"Essential Health benefits" means, to the extent covered under the Plan, expenses incurred with respect to covered Services, in at least the following categories: ambulatory patient Services, emergency Services, hospitalization, maternity and newborn care, mental health and substance use disorder Services and devices, laboratory Services, preventive and wellness Services, chronic disease management, and pediatric Services including oral and vision care. **The prohibition of annual dollar limits under the Affordable Care Act applies only to Essential Health Benefits.**

"Patient Protection and Affordable Care Act of 2010" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Healthcare and Education Reconciliation Act of 2010 (Public Law 111-152).

A Member's health coverage may not be rescinded (retroactively terminated) unless:

- The Employer or a Member (or a person seeking coverage on behalf of the Member) performs an act, practice or omission that constitutes fraud; or
- The Employer or Member (or a person seeking coverage on behalf of the Member) makes an intentional misrepresentation of material fact.

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

PHP means Presbyterian Health Plan, a corporation organized under the laws of the state of New Mexico.

PHP Video Visit means a virtual visit with a contracted provider. These visits are scheduled through the myPRES Portal.

PPACA means Patient Protection and Affordable Care Act.

PPO means Preferred Provider Organization.

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

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

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

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

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

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

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 Administrative Services Agreement (ASA) or non-Group Membership Letter of Agreement.

Prescription Drugs/Medications means those drugs that, by Federal law, require a Provider's prescription for purchase. 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 **Express Scripts** at **1-866-217-3774.**

Primary Care Provider or Practitioner (PCP) means a Healthcare Professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to Members, who may initiate their referral for specialist care, and who maintains continuity of patient care. Primary Care Practitioners shall include but not be limited to general Practitioners, family practice Practitioner/Providers, internists, pediatricians, and Obstetricians-Gynecologists, Practitioner/Provider Assistants and Nurse Practitioners. Other Healthcare Professionals may also provide primary care as necessitated by a Member's healthcare needs. Members enrolled in the PPO plan have the choice of an In-network or Out-of-network Practitioner/Provider based on availability, without a referral.

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

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

Provider means any duly licensed Hospital or other licensed facility, Provider, or other Healthcare Professional authorized to furnish Healthcare Services within the scope of their license.

Provider Non-Discrimination

PHS Act Section 2706(a)(3), as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable state law "PHS" Act section 2706(a) prevents " a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures. "Similar language is included in section 1852(b)(2) of the Social Security(4) Act and implementing HHS regulations(5).

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

Means the amount determined to be payable by Presbyterian Health Plan for Services rendered to Members by Out-of-network Providers, based upon the following criteria:

- Fees that a professional Provider usually charges for a given service;
- Fees which fall within the range of usual charges for a given service filed by most professional Providers in the same locality who have similar training and experience; and
- Fees which are usual and customary, or which could not be considered excessive in a particular case because of unusual circumstances.

Reasonable Charge or Reasonable and Customary (R&C) Charge means the amount determined to be payable by Presbyterian Health Plan for Services rendered to Members by Out-of-network Providers, based upon the following criteria:

- Fees that a professional Provider usually charges for a given service;
- Fees which fall within the range of usual charges for a given service filed by most professional Providers in the same locality who have similar training and experience; and
- Fees that are usual and customary, or which could not be considered excessive in a particular case because of unusual circumstances.

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

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

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 **twenty-four hours** a day.

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

Service Area means the entire state of New Mexico.

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.

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.

Skilled Nursing Care Means Services that can be provided only by someone with at least the qualifications of a licensed Practical Nurse or Registered Nurse.

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

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

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

Special Medical Foods means nutritional substances in any form that are:

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

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

Spouse - Legally married husband or wife.

Statutory Minimum HDHP Deductible means the minimum Deductible that a health plan must have to be a City of Rio Rancho High Deductible Health Plan under Internal Revenue Code Section 223. To be eligible for HSA contributions, an individual must have HDHP coverage and no other health plan coverage (with very few exceptions) up to the Statutory Minimum HDHP Deductible for the current year.

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 this Agreement or, in the case of an individual Contract, the Person in whose name the Contract is issued.

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

Summary of Benefits and Coverage means the written materials required by state law to be given to the Covered Person/Grievant by the Healthcare Insurer or Contract holder.

Summary Plan Description (SPD) 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.

Superintendent means The Superintendent of Insurance.

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

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

TEFRA means Federal law regarding the working-aged.

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

Terminally Ill Patient means a Member with a life expectancy of six months or less as certified in writing by the Attending Provider.

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 that 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.

Two-Party Coverage means coverage for the employee and his/her spouse or coverage for the employee and one Dependent child.

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 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.

Urgent Care Illness means an unexpected illness that is non-life-threatening that requires prompt medical attention. Some examples of urgent situations are sprains, strains, vomiting,

cramps, diarrhea, bumps, bruises, fever, small lacerations, minor burns, severe stomach pain, swollen glands, rashes, poisoning and back pain.

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.

Video Visit means an online consultation between a designated Practitioner/Provider and a patient about non-urgent healthcare matters.

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

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

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

This Summary Plan Description is issued to the Group for the Subscriber named in an Application received and accepted by Presbyterian Health Plan, a New Mexico corporation. The terms and conditions appearing herein and any applicable amendments are part of this Summary Plan Description.

IN WITNESS THEREOF, Presbyterian Health Plan has caused this Summary Plan Description to be executed by a duly authorized agent.

PRESBYTERIAN HEALTH PLAN

Brandon Fryar
President
Presbyterian Health Plan

Acceptance Page

City of Rio Rancho agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of the City of Rio Rancho POS Medical Plans: Copay Plan.

By:

Signed _____ _____

Date

City of Rio Rancho Manager

Trying to quit? You can do it!

Ready to try something new? You may have tried to quit in the past without success. Clickotine will give you the boost you need to quit—and quit for good.

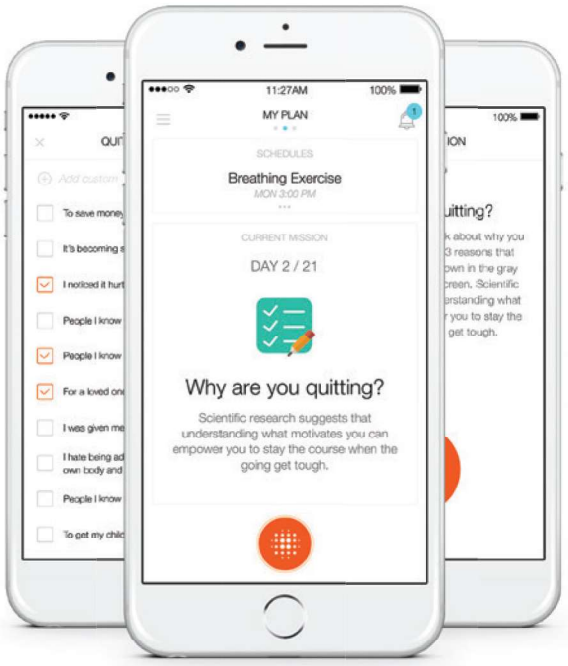
The challenging road to quitting

If you've been smoking for some time, you know how hard it can be to quit. In fact, nearly 70% of adult smokers want to stop. People trying to quit often feel alone in their daily struggle. The good news is that it's never too late to work on quitting, and once you do, your health will improve quickly and significantly.

Introducing the Clickotine mobile application

Clickotine is an innovative program that uses clinically-driven app technology to help you create and stick to a quit plan and overcome nicotine cravings. Based on clinical trials and data, Clickotine has a high success rate and includes these key features:

- ☑ **Personalized messaging:** Receive personal messages that keep you on track toward your quit goal.
- ☑ **Controlled breathing:** Monitor and control your breathing—an effective way to reduce nicotine withdrawal symptoms.
- ☑ **Real-time social support:** Post comments and share encouragement with others trying to quit.
- ☑ **Replacement distractions:** Get help diverting cravings to healthier actions.
- ☑ **Money saved:** Track how much money you've saved since your quit date—a powerful motivator for quitting.
- ☑ **Health recovered:** See how quitting has improved your health. As soon as you quit smoking, your body begins to recover.
- ☑ **Journaling:** Document how you're feeling during your quit journey. Not only can it help to relieve stress, it can also help you understand your smoking triggers, when you track your thoughts and feelings during your quit effort.



Ready to get started?

1. **Go to Try.Clickotine.Com** and enter Client ID code: 731C73
2. **You will receive an email** with your secure member code and a link to download the app.
3. **Create an account** and you're on your way to quitting smoking.

For more information on how to sign up, contact Customer Service at (505) 923-5678 or 1-800-356-2219.

MPC121815 SERFF: PBHP-131766006, PBHP-131766079, PBHP-131766082

Clickotine®

A Digital Therapeutics™ Program for Smoking Cessation

Finally, Personalized Help to Quit Smoking

Visit **www.clickotine.com** for details.

For more information on how to sign up, contact customer service at (505) 923-5678 or 1-800-356-2219.

Partner Dashboard

Providing a web-based portal for partners enables observation of population trends, as well as detailed user-by-user data streams

Social Engagement

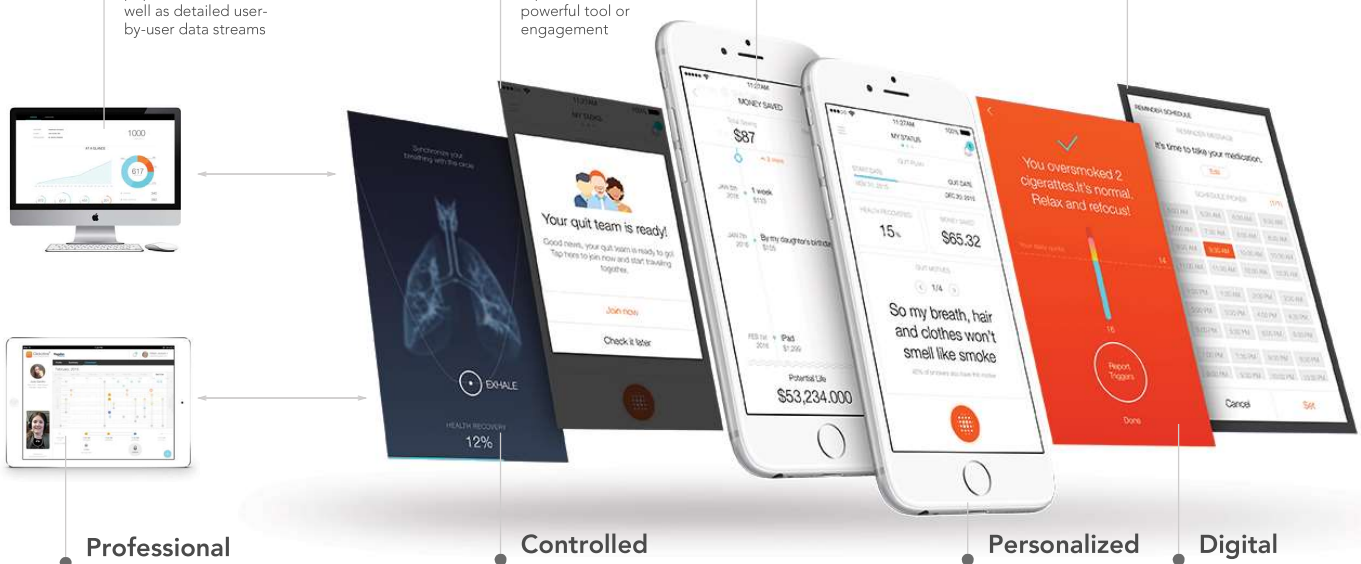
Real-life support from friends, family and community. Quitting with a small quit team is proven to be a powerful tool or engagement

Financial Incentives

Out-of-app incentives such as refunds & reimbursements provided by partners

Medication Adherence

Individualized reminder system to optimize use of effective treatment



Professional Caregiving

Real-time access to qualified professional caregivers, quit coaches & counselors

Controlled Breathing

Controlled, mindful breathing experiences coupled with multi-sensory stimuli

Personalized Messaging

Adaptive text messages tailored to user profile, and provides contextualized, personalized support and guidance

Digital Diversions

Timed and targeted strategies to cope with cravings, withdrawl symptoms & lapses

MPC121815

SERFF: PBHP-131766006, PBHP-131766079, PBHP-131766082

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Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

CLICK THERAPEUTICS™

Magellan HEALTHCARE℠

For technical assistance contact support

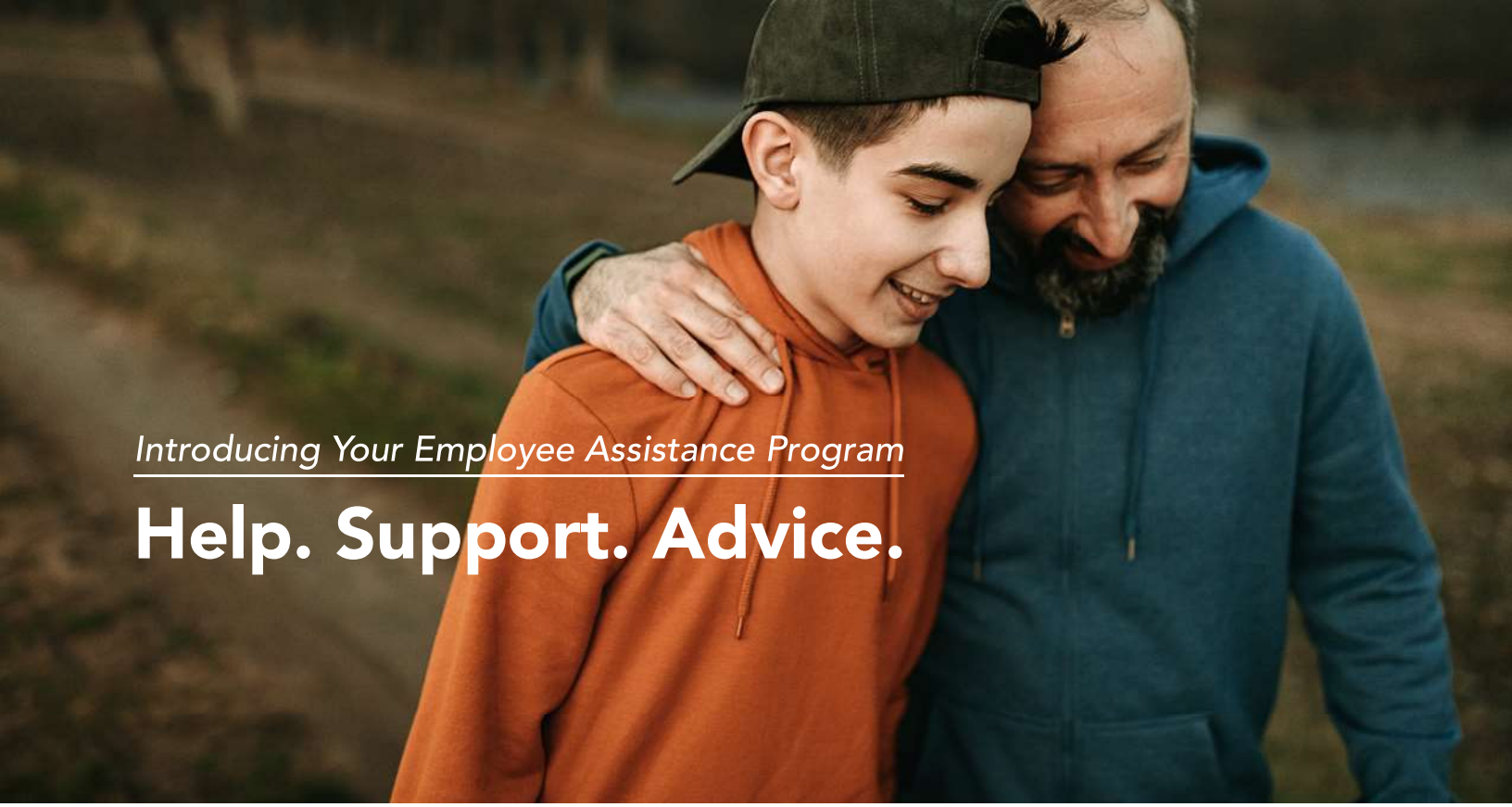
Call 877-352-5425

Monday - Friday 9AM - 6PM ET

support@clicktherapeutics.com

ANDROID APP ON Google play

Available on the App Store



Introducing Your Employee Assistance Program

Help. Support. Advice.

If you or your loved ones face difficult situations like stress, relationship challenges, grief, loss or substance use, we're here to help. Learning how to cope with these issues can improve your overall well-being.

You and your household members can get up to six employee assistance visits per issue through The Solutions Group, a division of Presbyterian Healthcare Services.

Employee Assistance Program (EAP) services are short-term, confidential counseling sessions conducted by local licensed providers and can include:

- mediation services
- substance use assessments and referrals
- 24-hour emergency services
- support for supervisors and managers
- referrals for additional support

When faced with complex personal or work-related challenges, let our EAP providers help. To schedule an appointment with an EAP counselor or for after-hours crisis support, please call 1-866-254-3555 or (505) 254-3555.

Services provided by:

The Solutions Group

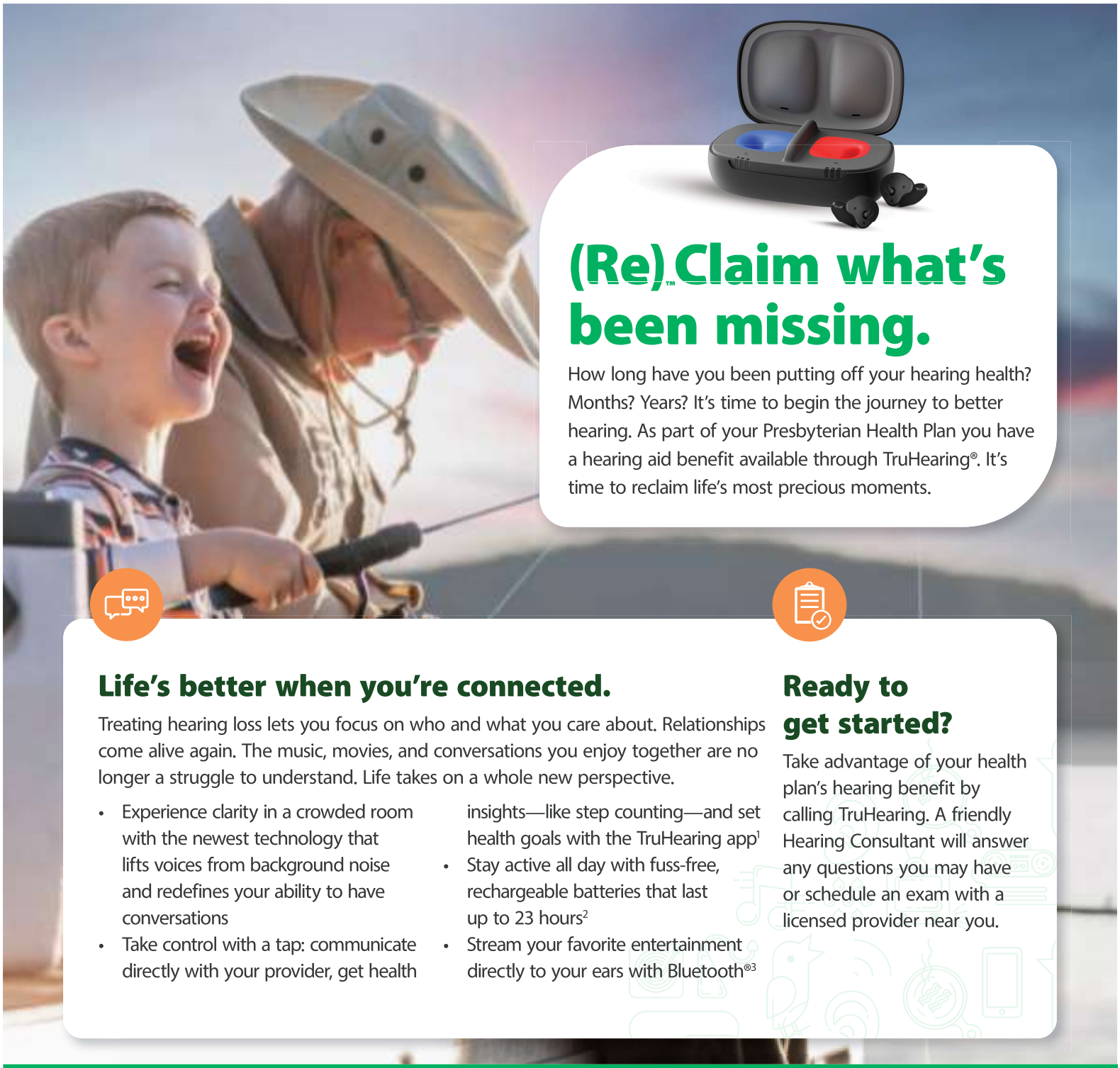
PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

MPC032186
PHP-148 0421

PRESBYTERIAN Health Plan, Inc. | TruHearing®

1-833-731-4168 | TTY: 711



(Re)Claim what's been missing.

How long have you been putting off your hearing health? Months? Years? It's time to begin the journey to better hearing. As part of your Presbyterian Health Plan you have a hearing aid benefit available through TruHearing®. It's time to reclaim life's most precious moments.

Life's better when you're connected.

Treating hearing loss lets you focus on who and what you care about. Relationships come alive again. The music, movies, and conversations you enjoy together are no longer a struggle to understand. Life takes on a whole new perspective.

- Experience clarity in a crowded room with the newest technology that lifts voices from background noise and redefines your ability to have conversations
- Take control with a tap: communicate directly with your provider, get health insights—like step counting—and set health goals with the TruHearing app[1]
- Stay active all day with fuss-free, rechargeable batteries that last up to 23 hours[2]
- Stream your favorite entertainment directly to your ears with Bluetooth®[3]

Ready to get started?

Take advantage of your health plan's hearing benefit by calling TruHearing. A friendly Hearing Consultant will answer any questions you may have or schedule an exam with a licensed provider near you.

Give TruHearing a call today.

1-833-731-4168 | TTY: 711

Hours: 8am–8pm, Monday–Friday

PRESBYTERIAN Health Plan, Inc. | TruHearing®

1-833-731-4168 | TTY: 711

Your 2023 Hearing Coverage

Your benefit covers up to two Advanced or Premium hearing aids per year at low copayments.

	TruHearing *Advanced* 11 Styles | 32 Channels	***TruHearing*** *Premium* 14 Styles | 48 Channels	
Your Plan	**Retail: $2,320/aid**	**Retail: $3,250/aid**	Routine Exam In-Network[4]
Presbyterian Health Plan	**$699** copay/aid	**$999** copay/aid	**$45** exam copay

Rechargeable battery option is available on select styles for an additional $50 per hearing aid.

Schedule an appointment

1-833-731-4168 | TTY: 711

Hours: 8am–8pm, Monday–Friday

Check your hearing

TruHearing.com/Presbyterian-HS

Your benefit also includes:

+ Risk-free 60-day trial period
+ 1 year of follow-up visits
+ 80 free batteries per non-rechargeable hearing aid
+ Full 3-year manufacturer warranty

[1] Ask your provider to enable virtual appointments. In-app interfacing requires provider activation.
[2] Available on select models.
[3] Smartphone-compatible hearing aids connect directly to iPhone®, iPad®, and iPod® Touch devices. Some TruHearing models connect to Android® phones directly. Connectivity also available to many Android phones with use of an accessory. TV streaming available through most TVs with use of an accessory.
[4] Must be performed by a TruHearing network provider.

 Retail pricing based on prices for comparable aids. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant.
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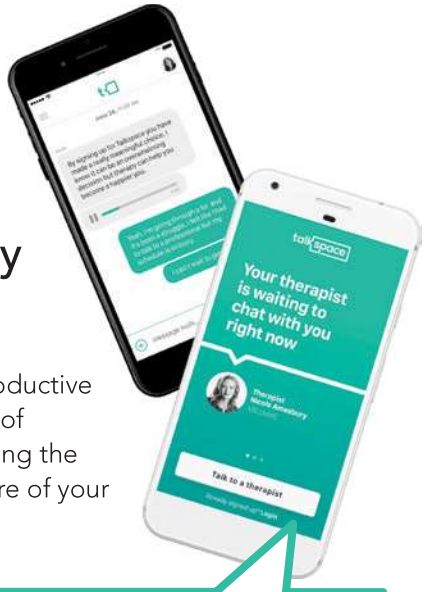
Talkspace for Behavioral Health

Mind Your Mental Health with Messaging Therapy
A new solution for emotional wellbeing



Mental health affects every aspect of our lives. When you feel good, you are more productive and happier, and you can handle life with more ease. When your mental health is out of balance, like when you are stressed or worried, it can keep you from doing and enjoying the important things in your life. Just like you take care of your body, you need to take care of your mind. Magellan makes it easy to do that with messaging therapy from Talkspace.

What is messaging therapy?

Messaging therapy enables you to find and communicate with a therapist anytime via your web browser or the Talkspace secure mobile app. No more having to wait months for an appointment or needing time off to visit a therapist in a busy office. With Talkspace, you can participate in therapy at a time and place that is convenient for you.

Talkspace therapists have a proven track record of using messaging therapy to help with a variety of conditions including anxiety, depression, substance abuse, panic and bipolar disorders, all of which can be debilitating if not treated. They can also help manage the unique challenges some people face, like being a single parent, a veteran or a member of the LGBT community.

How it works

With Talkspace there are no appointments. You can send your therapist a message whenever you need to, and they will engage with you daily, five days a week. With a network of over 2,000 trained, licensed therapists, Talkspace will connect you with a dedicated therapist based on your needs, preferences, therapist availability and expertise. You can contact your therapist through unlimited text, video and audio messages.

What's in it for you?

For some people, traditional in-person therapy can be intimidating, difficult to arrange, time consuming and expensive. For others, a lack of appointment availability or coverage in remote areas may cause access difficulties.

> *"I absolutely love the ability to text, video message, or voice message whenever I need support. The growth I have been able to accomplish in less than a year is far more than I ever was able to get from visiting a therapist in person for years on end."*
> *– Amanda, Talkspace User*

With Talkspace you can:

- Engage with a therapist the same day that help is needed, not weeks later.
- Get matched to a therapist based on your unique needs.
- Develop a one-on-one relationship with the same therapist throughout your engagement.
- Live a happier, healthier life.

Getting started

- Go to www.talkspace.com/php to access the program.
- Enter information about yourself.
- Fill out the section about your history and preferences.
- Select a therapist.

**Members on qualified High Deductible plans will be responsible for the cost of the services until they have met their deductible and co-insurance requirements. High Deductible members can go to talkspace.com to access the self-pay option.*

talkspace

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Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

MPC121809
PHP-62 0219

SERFF PBHP-131766006, PBHP-131766079, PBHP-131766082

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) 923-5420, 1-855-592-7737, 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) 923-5124, or **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

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

Address: U.S. Department of Health and Human Services200
Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

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

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

PRESBYTERIAN

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, kojį' hódíílnih 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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